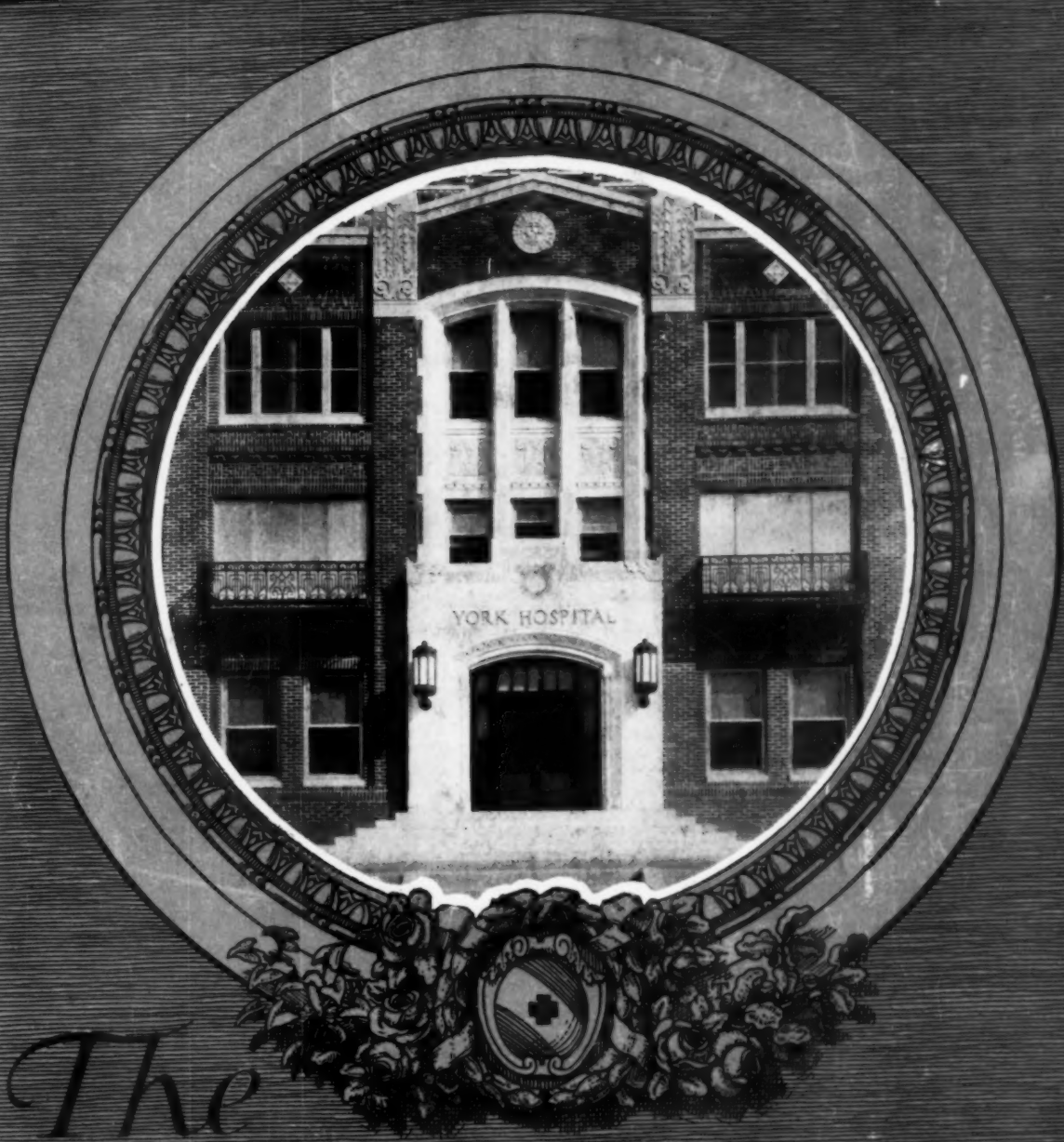

The MODERN HOSPITAL

Vol. XXXIX OCTOBER, 1932 No. 4

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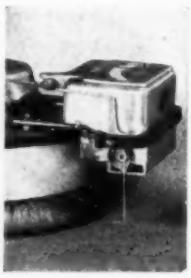

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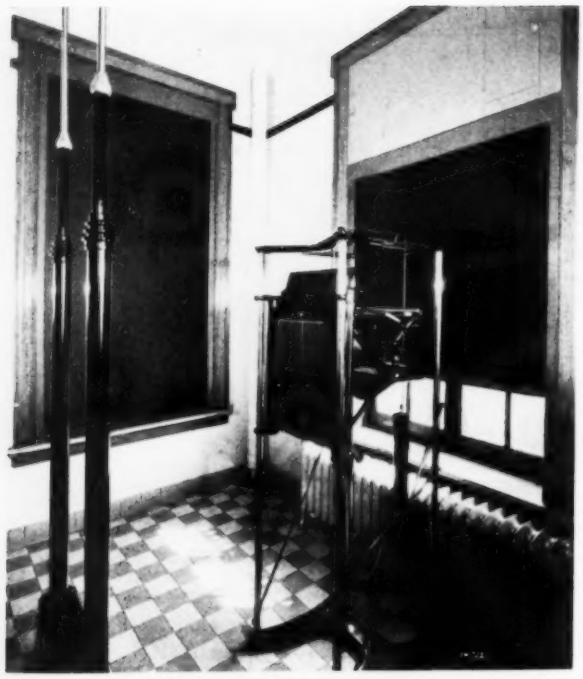
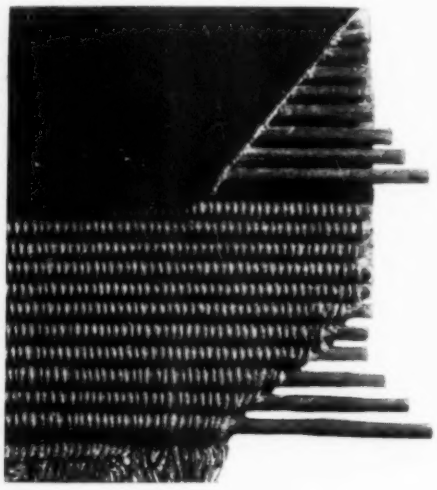


Corner of X-Ray Room, Mercy Hospital, Chicago, Showing Installation of St. Clair Shades.



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THE MODERN HOSPITAL

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A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums.

VOL. XXXIX *October, 1932* NUMBER 4

Hospitals Must Prepare Themselves for a New Era

A. H. A. Presidential Address

By PAUL H. FESLER

President, American Hospital Association

IT HAS been the desire of the board and officers of the American Hospital Association to aid all hospitals in planning programs for the welfare of the people they are called upon to serve. We have endeavored to cooperate with the medical profession and allied groups in all efforts to bring scientific medical care within the reach of all classes.

In order to determine how best to serve the people through hospitals, three meetings have been held with the presidents and secretaries of state and district hospital associations—one in Toronto and one in Chicago. The third meeting of this group was held here today. In addition, the president or secretary has attended most of the meetings of these local associations. This was made possible by an arrangement of dates suggested by John A. McNamara, executive editor, THE MODERN HOSPITAL.

We who direct hospitals must remember that while it is important to balance the budget, it is vastly more important that we do not sacrifice the ideals that ensure scientific and humane care for our patients. This assurance can be given only by the use of trained physicians, aided by trained nurses, dietitians, social workers and technicians, and with the help of modern diagnostic equipment. To sacrifice any of these would not be economy.

During this past year we have been in close contact with allied groups. Representatives of the association have taken part in many conferences affecting hospitals and medical practice.

Representatives have appeared on programs of the nursing associations, the hospital conference of the American College of Surgeons, the American College of Physicians and the American Medical Association. We have had representatives on special committees on unemployment and relief, and have been requested to participate in the conference to be held in Washington this week to coordinate the work of all relief organizations.

While the American Hospital Association is effective in forming policies and dealing with matters of national importance, the state or provincial hospital associations are much more effective in dealing with local conditions affecting our hospitals. They should all be geographic sections of the American Hospital Association. In addition to their committees having to do with local matters, there should be committees created to work with the committees of the American Hospital As-

sociation in matters affecting other states. Most hospital legislation comes from state legislation, so it is important that each state association be kept intact, but for the purpose of meetings, several states meeting together as a district group are better able to attract talent. I recommend that the United States and Canada be divided into a number of districts and that one vice president be elected from each district. This would bring the field in more direct contact with the national association. The vice presidents would be able to advise boards, superintendents, building committees and communities in matters pertaining to their hospitals.

When these states and districts are properly organized we should have a house of delegates duly elected and with authority, to form the policies of the American Hospital Association. Our meetings of state association presidents have shown the possibilities of such a group.

The association is called upon to serve the entire hospital field—not only in the United States and Canada. Inquiries come from all parts of the world, and information is furnished promptly from the association's library and service bureau.

The library and service bureau becomes more and more useful. The members of the association should help increase its usefulness by supplying books, pamphlets and plans, making this material available to the entire field. The service of the bureau has not been curtailed in any sense, and will be of increasing value to hospitals and those interested in hospitals.

Financial Standing Is Satisfactory

In spite of the depression, our finances are on a sound basis. The loan on the property of the association has been reduced since last August from $50,000 to $32,500—a reduction of $17,500. Our operating expenses have all been met. This is due to the splendid management on the part of our executive secretary and the treasurer of the association. The trustees will submit a plan of refinancing our loan. This will enable the association to give more attention to the many problems which present themselves, and which we cannot undertake for lack of funds. In traveling about, I was impressed with the many suggested activities—but most of them call for money. It is really remarkable that the capital indebtedness of the association has been reduced from $120,000 to $53,000 in the short space of six years.

Our membership shows a net increase of forty-four institutional and 111 personal members—total, 4,280—and the income from institutional members has exceeded the estimates by more than $1,000 for the present year.

I believe this shows that hospitals and the members appreciate the value of the association, especially in these times of stress and strain.

There is great lack of facilities for the care of convalescent and chronic patients. As a result many beds in hospitals for acute conditions are caring for such patients at great cost to the patient and the community. If the public hospitals could confine their service to the care of such patients and pay the voluntary hospitals for the care of acute medical and surgical patients, it would help to solve the problem of low occupancy and would mean greatly improved service to these acute cases at a lower cost to the taxpayers. Many public hospitals could be closed today if the government agencies would use the available beds in voluntary hospitals. The cost would be less, as most hospitals would not charge for the overhead and depreciation which are always present in the public institution.

Why So Few Mental Hospitals on the Roll?

Notwithstanding the fact that over half the hospital beds are for the care of mental diseases, we find few such hospitals are members of the association. This is a great field of service. We have heard much of the forgotten man—we must see to it that the 400,000 patients confined in these institutions are not forgotten and denied the advances in the field of medicine in connection with mental diseases. Last year 61,000 beds were added to the beds of this country, 40,000 of which were in hospitals for the care of mental diseases. The best possible way to stop the need for such institutions is by the establishment of psychopathic hospitals in each state (preferably in connection with universities) and for general hospitals to make provisions for the care of borderline cases.

I strongly recommend that the association take increased interest in this field of service. This should be a part of the program of our new section on public hospitals.

According to THE MODERN HOSPITAL YEAR BOOK just issued, 3,500 of the 7,375 hospitals have less than forty beds. These hospitals have a low occupancy, and many of them are rendering important service to the community. We must take unusual interest in these institutions. This can best be done through local associations and by furnishing information through our bulletins for their benefit. There is no finer service rendered than through a real community hospital, which appreciates its responsibility to all classes of citizens. They should be complete not only for the care of general medical and surgical cases, but for psychiatric, tuberculous and contagious

patients. Such hospitals are entitled to subsidy for the care of the indigent. I hope the association will continue to encourage such institutions. The larger hospitals should take special interest in supplying trained personnel for the small hospital. These hospitals should be the center of all health activities in their community.

It is deplorable to notice that some of the best hospitals in this country are administered by men with no experience or training in hospital administration. It seems that it would be for the benefit of our patients if a college of hospital administration could be created to train hospital executives. These trained executives would be known as fellows of hospital administration. A board of regents should be created and admission to the college be on a similar basis as fellowship in the American College of Surgeons. A candidate to be accepted should have at least five years' experience in a private and acceptable hospital and should be admitted by examination on the basis of a thesis. It is ridiculous to think that men without any training whatsoever are permitted to head institutions responsible for the saving of lives and representing millions of dollars. This would not be possible in any business organization.

We regret little or no definite progress is being made in the training for the work of hospital administration. As a result, many are entering the hospital field as superintendents with little or no preparation or fitness for such important work. Some are succeeding, some are failing, and all are blundering for many of their early years in this work.

Better Care Needed for Crippled Children

The care of crippled children is an important function of our hospitals. Most states have made some provision for the care of such patients by the establishment of special hospitals; however, few have realized the magnitude of the problem.

A hospital of fifty beds serving seven or eight states will never be able to correct the deformities of forty or fifty thousand children. During the past few years poliomyelitis epidemics have occurred in many sections of the country. In most instances the possibility of prevention and research has been entirely neglected by both the hospitals and the medical profession. Hospitals should take the lead in such programs.

I feel that our state associations should see that special levies are voted for the care of such patients in approved voluntary or private hospitals. This is the only way prevention and care of cripples can be accomplished in an effective manner.

Nursing and the processes involved in the education of nurses still constitute a major problem.

The nursing set-up in our hospitals and the processes involved in the education of nurses are still causing much anxiety among our members. Our association has participated in the studies conducted by the Committee on the Grading of Nursing Schools, both by contribution of funds as well as by membership on the committee itself. A large and important work has been done by the committee, but our constituency has for some time been inquiring how this work is to be applied to the solution of the problem. We feel that this demand is justified and have sought to make reply.

The A. H. A.'s Responsibility to Nurses

Dr. William Darrach, chairman of the grading committee, in a report on the work of the committee before this association last year, stated the function of the grading committee to be a fact-finding one; that the solution of the problems is "the responsibility of each individual or group who shares the burdens of the sick. They can be solved by study, discussion and united action." He urged each interested group to make a careful study of the work of the committee.

The assumption at this time was that the grading committee would conclude its labors during the following year. In accordance with the suggestions made by Doctor Darrach, a special committee was appointed by the officers of the American Hospital Association to study the report of the grading committee to estimate results and to seek to discover how the association fits into the picture and what responsibilities the association now has as a result of the studies that have been made.

The recent announcement coming from the officers of the grading committee that there would be no minimum standard suggested for schools of nursing was a keen disappointment to many of our members. It had been hoped, and the basis for this hope had been found in the first statement of purpose given by the committee, that some "definite standard of measurement" would be offered as an aid and support to those who were earnestly seeking to improve the educational standards involved in the training of their nurses.

The decision of the grading committee now places the matter squarely before this association, and it will be our responsibility, in conjunction with all other agencies vitally interested in the same problem, to take up the problem where the grading committee leaves it. The American Hospital Association should make provision for a council on nursing education. This council should proceed to work out a program involving a minimum standard which might serve as a guide to the weak but in no sense be a deterrent to those

that have the vision and ability to forge ahead. I make this suggestion on behalf of the hundreds of hospitals which have been waiting for five years for a decision which would serve them in working out their educational programs. What I have said should not be interpreted as a criticism of the grading committee. The results of its work have already helped hospitals all over the country to raise standards in their schools of nursing.

What Has Been Done for the Veteran

During the past year we have been active in efforts to induce Congress to amend the law to make it possible for exservice men with nonservice connected disabilities to be cared for in civilian hospitals. At the present time service connected cases may be cared for in any hospital but nonservice connected cases must be cared for in government hospitals.

This was discussed at our last meeting and the board of trustees passed a resolution recommending to the Veterans' Bureau, the veterans' organizations, Congress and all others having the welfare of the veterans at heart, a consideration of the facilities for the care of injuries and acute illnesses offered by available civilian general hospitals under conditions similar to those now enjoyed by veterans suffering from service disabilities, and further recommending that action be taken so that the use of available civilian hospitals, with provision for proper medical care, be the privilege of all veterans requiring general hospital treatment.

This resolution was not made public—not even to the members of the association. We felt it was much better to work through the American Legion and other veterans' organizations. During the year we have joined with the American Medical Association and had conferences with the American Legion and the Veterans' Administration and have had a hearing before Congress.

It still seems that the only way to obtain results is to convince the legion that these exservice men would receive much better care if treated in their local hospitals by the local physicians.

We have supplied the government with a list of 33,000 beds in civilian hospitals, most of which are approved by the American College of Surgeons and other standardizing agencies. We have submitted information which would show that the cost would be much less if these patients were cared for in civilian hospitals, and that the quality of care would be at least as good as that now given to these men.

We have been unable to make any impression whatever upon the Veterans' Administration. After we have given absolute proof, they follow with flat statements to the effect that the average cost for caring for patients in civilian hospitals is $8 a day and the average cost in government hospitals is $3.50, $4 or $5. It seems that all of the statements differ.

The legion meets in Portland on the same dates as this meeting. C. J. Cummings, Tacoma, Wash., and others from that vicinity, will meet with the special committee which was appointed by the national commander to study this situation and will participate in the proceedings of the rehabilitation committee. We hope that the results of this meeting will make it possible for us to approach Congress and have the law amended.

We are standing on the threshold of a new era and it is up to the hospitals whether or not we shall make the most of our future opportunities. We must recognize that these last few months have been extremely trying, that normal support for voluntary hospitals on the one hand and tax support for municipal hospitals on the other have been greatly curtailed and that adequate service to the patient is in jeopardy unless we agree upon a program whereby the entire public, and particularly the philanthropically minded public, can be educated to an appreciation of the worth of the hospital to the community.

Every effort must be put forward to see that the sick and injured shall not want for the best of hospital care. This is an emergency and we must meet it in the same spirit that hospitals have met other emergencies, since the first institution was founded. The people on this continent must be taught that the hospital is an integral part of the community, that their health, happiness and prosperity depend to a large degree upon the efficiency of all institutions, and they must be taught that support of institutions is an obligation of every person within the borders of the city.

A Call to Arms

However, let me at this time sound a note of caution. We who administer the hospitals of the United States and Canada must put our house in order and merit the good will that we seek. We cannot lay ourselves open to criticism and expect the support of the public. Very often in the past the public has had just cause for complaint, particularly in some of our municipally supported hospitals that have come under the domination of the corrupt politicians.

It is my view that this association should investigate all hospitals of this type to the end that grafters, thieves and ghouls may find no haven behind the cloak of charity and that all municipal hospitals be brought up to the standards of the highest examples of these institutions.

Improved Negro Hospital Facilities Is Hopeful Sign for South

By MARY ROSS
Julius Rosenwald Fund, Chicago

A BELATED heat wave had fallen over the Southeastern states the week that I started on a round of informal visits to hospitals for Negro patients. Clouds of dust hung over the fields and filtered through the train windows. Late crops, already stunted by the season's drought, lay shriveling in the sun. Tired, rasping voices in streets and hotel lobbies bore witness to the strain that the weather, the crop failure and the industrial depression had laid over many of the people.

By contrast the hospitals themselves were a series of oases. On entering their doors one seemed in another world of cleanliness, coolness and courtesy. Only one of the three hospitals described in this article had the advantage of a new plant, but all had been scrubbed to the proverbial point at which one would have been willing to eat off the floor. Low voices, deft hands, and

harmonious movement of well ordered professional régime surrounded sick people who looked far more content than the presumably healthy individuals one passed on the streets. These three institutions were small, far from rich, working in hard times to serve the less advantaged group in their communities; staffed, with a few exceptions, entirely by members of a race that has won professional status only in recent decades. Yet in all of these hospitals one felt immediately a sense of purpose, interest and orderliness, a concern for the patient and for professional standards that are the essence of the honorable tradition of "hospital."

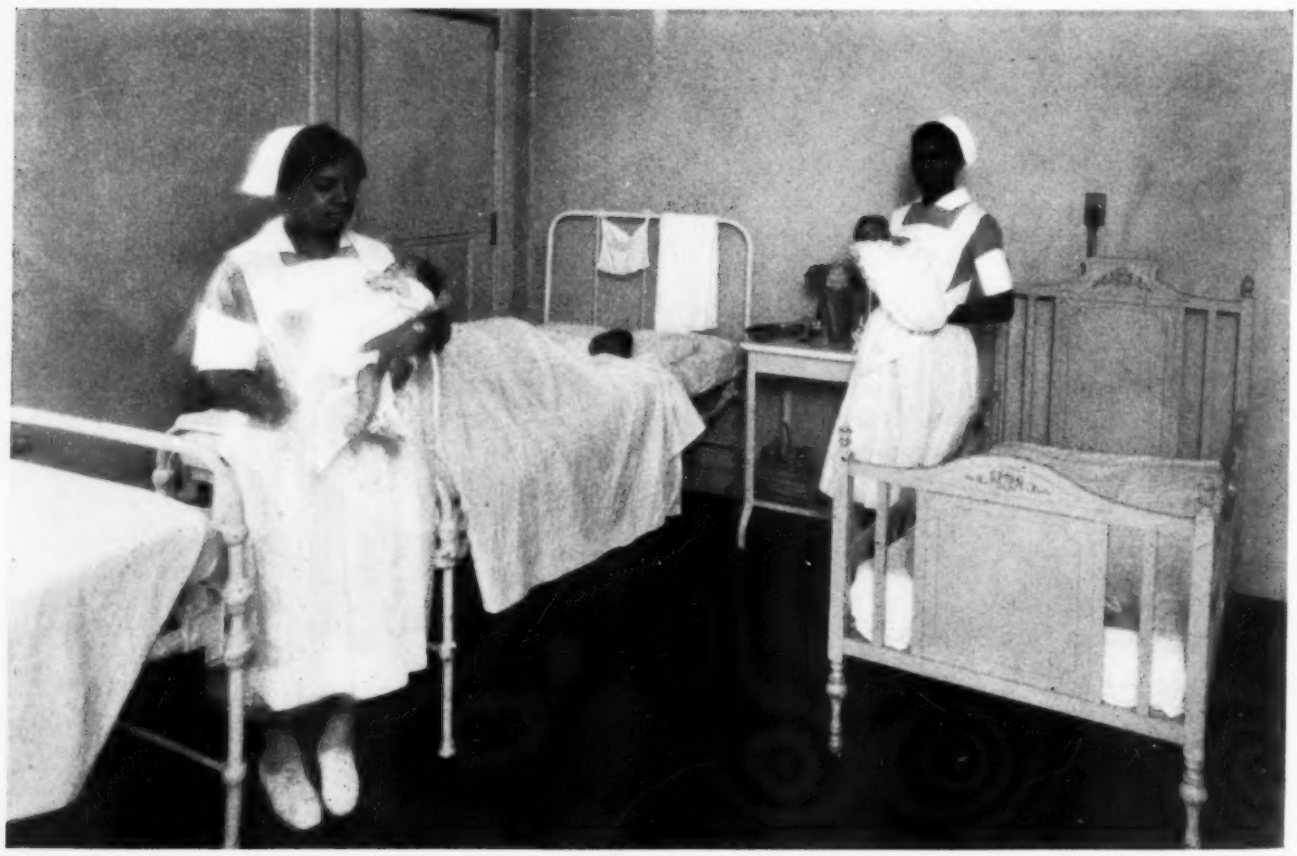
The Oldest Negro Hospital

The Good Samaritan Hospital, Charlotte, N. C., is said to be the oldest hospital exclusively for colored patients now in operation in the South. For the first seven years of its existence the hospital occupied a private dwelling. In 1888 it was formally established under the auspices of the Protestant Episcopal Church in a brick building housing only twenty patients. The Good Samaritan Hospital now occupies a group of brick, slate roofed buildings, representing a capital value of $159,000. An active and devoted group of white churchwomen serve as the hospital's self-perpetuating board of managers. Election of new members must be confirmed by the bishop of the diocese of North Carolina.

The present Good Samaritan Hospital has forty-five beds and two bassinets in use. As need develops, this capacity can be extended to sixty-five beds. In 1930 the existing buildings were remodeled and modernized and a new wing for a nurses' home and out-patient department was added at an approximate cost of $67,000, toward which the community contributed $20,000, the Duke Endowment $32,000 and the Julius Rosenwald Fund $15,000.

While the superintendent of the hospital is a white graduate nurse who has had experience in hospital administration, the nursing staff, which includes three graduate and an average of fifteen student nurses, is colored. Applicants for training must have completed four years of high school. A course of 156 weeks is required for graduation, with six hours a week of class and laboratory work the first year, nine the second and eight the third. Student nurses receive a monetary allowance of $9 a month.

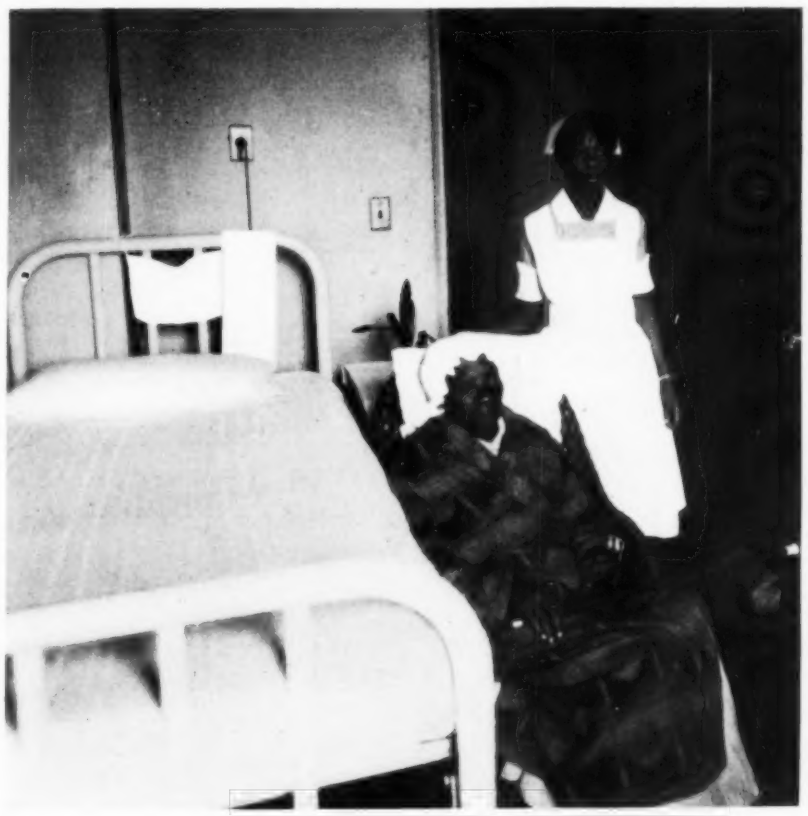
Six white and three Negro physicians serve as a more or less formal attending staff, at the request of the board of managers. The hospital is open, however, to all reputable practicing physi-



One section of the children's ward in Good Samaritan Hospital, Charlotte, N. C.

cians, regardless of color, and is used during the course of a year by seventy or more, the majority of them white. Ward patients may be treated by their private physicians. The rates are $3 for care in single rooms, and $2 for two-bed rooms and wards. With the recent provision of quarters in the new building, out-patient service has been started and is being organized.

During the year 1930, the Good Samaritan Hospital cared for 927 patients at a daily per capita cost of $2.65. There were 8,641 total days of care provided, of which 4,105 were full-pay, 1,021 part-pay and 3,515 free. Out-patients totaled 284. One thousand three hundred fifteen laboratory examinations and ninety-six x-ray examinations and treatments were given. The x-ray equipment, housed in the hospital, is owned and operated by two physicians who provide all supplies and pay the hospital about a quarter of the net receipts. The surgical service included 174 major and 542 minor operations. The hospital's total receipts for the year were $23,177, divided as follows: from full-pay patients, $10,568; part-pay patients, $1,228; church donations, $1,069, including commodities valued at $500; municipal and county subsidies for the care of indigent patients, $4,025, and the Duke Endowment subsidy of $1 a day toward the care of indigent patients (available to all accepted hospitals in the Carolinas), $6,287. The hospital also has an endowment of $5,000.



This old mammy has been in Good Samaritan Hospital since November, 1931.

Another well organized general institution for Negro patients in North Carolina is St. Agnes' Hospital, Raleigh; like the Good Samaritan Hospital in Charlotte, it owes its inception to the missionary spirit of a church group. Founded in 1896, the hospital occupies a group of stone, brick and wood buildings on the campus of St. Augustine's College, an institution for colored students maintained by the Protestant Episcopal Church. It is approved by the American College of Surgeons, and is approved for internship by the Council on Medical Education and Hospitals of the American Medical Association. The self-perpetuating board of trustees of the college also serves in the same capacity for the hospital. The superintendent is a white registered nurse who has had long experience in hospital administration.

The lawn, trees and substantial buildings of the college campus give St. Agnes' Hospital a setting of peaceful and purposeful tradition. Within this the hospital itself owes to its superintendent an atmosphere of which an institution would be proud—the product of courage, consideration, administrative skill and a saving grace of humor in the face of difficulties occasioned by its most limited finances. St. Agnes' owes much of its early development to the devotion of a white surgeon who is still actively identified with it. Now a great part of the surgical service is performed by a colored member of the medical staff who has long been associated with him in this work. Relationships of the medical, nursing and administrative staffs are exceptionally harmonious and pleasant—an achievement that adds greatly to the comfort of the patient and the economy and efficiency of the régime.

St. Agnes' Hospital has ninety beds and ten bassinets, comprising two single rooms at $3 a day, five two-bed rooms at $3, and eighty-eight beds in wards at $1 a day. In the two-bed rooms the $3 daily charge covers the cost of drugs, dressings and the like, for which an extra charge is made to private room patients. During 1930 its average daily occupancy was 67 per cent.

In the same year, St. Agnes' Hospital gave

20,235 patient days of care at an average per diem cost of $1.91. These figures do not include 3,158 days' residence of expectant mothers who work in the hospital for three months, usually before their confinement, to pay for their care at delivery. Free days of care given amounted to 11,686; part-pay, 4,756; full-pay, 3,793.

Twenty Physicians on Staff

The building of a new nurses' home in 1930 made it possible to remodel the former frame house to provide quarters for an out-patient department. In 1930, 805 patients made 2,684 visits to clinics in general medicine, surgery, gynecology and obstetrics, eye, ear, nose and throat, dermatology, urology, pediatrics and tuberculosis. Laboratory examinations, which are included in the regular charges and are made by the interns or at the state laboratory, totaled 278 for out-patients, and 3,567 for in-patients. The x-ray equipment is owned by a physician who charges pay patients directly, while the hospital tries to collect from others the cost of the films.

As in other Southern communities, agricultural depression in this district has caused a marked decline in the ability of patients to pay in recent years. Whereas the hospital used to have fifty or sixty pay patients under care at one time and only six or seven considered as "charity," now it is not unusual to find all the occupied beds filled with charity cases. The city of Raleigh appropriates $3,500 a year toward the expenses of indigent patients, and, like Good Samaritan and other acceptable hospitals in the Carolinas, St. Agnes' shares in the $1 a day grant from the Duke Endowment toward the care of these cases. The hospital has an endowment of $38,700 and in 1930 received church donations in cash and kind to the value of $5,400. Plant, building and equipment of St. Agnes' Hospital are valued at approximately $208,000.

The medical staff of St. Agnes' is composed of fourteen white and six colored physicians, appointed by the board of trustees. Regular well attended staff meetings are held monthly. Free cases are cared for by the staff, but physicians of both races, who are approved by the staff, may attend pay patients in the wards and private rooms. During the past year, thirty-three physicians treated cases in the hospital. The surgeon-in-chief is a white physician who has been actively connected with the hospital for more than thirty years, while the secretary of the medical board is a colored surgeon. There are two interns, both colored, and a resident physician who recently completed his internship at St. Agnes'.

Founded by Private Donation

The training school, accredited by the state board of nurse examiners, has thirty-six students, who must have completed a standard high school course. As at Good Samaritan, these nurses are required to have 156 weeks of training for graduation, during which nine hours a week are allocated during the first and second years and five and a half hours the third year for class and laboratory work. A grade of 75 per cent in every subject is required of each student who receives her di-

The L. Richardson Memorial Hospital, Greensboro, N. C.

The Good Samaritan Hospital and Nurses' Home, Charlotte, N. C.

ploma. A bonus of $25 is given each nurse at graduation.

The supervisory nursing staff is composed of four graduate Negro nurses, two of whom have had special postgraduate training. Nurses are adequately and pleasantly housed in a new building. The cost of building the new nurses' home, and of remodeling the old building as an outpatient department and quarters for interns, was met by grants from the women's auxiliary of the Protestant Episcopal Church, $30,000; the American Church Institute for Negroes, $1,000; the Duke Endowment, $15,000 and the Julius Rosenwald Fund, $15,000.

Medical social service at the hospital is done by students in the Bishop Tuttle School of Social Work and Religious Education and in St. Augustine's College. A separate room in the college library houses the medical library used by the nurses in training.

Unlike these two institutions which are conducted under church auspices, the L. Richardson Memorial Hospital, Greensboro, N. C., was initiated by a donation of $50,000 from the Richardson family, and incorporated in 1927 as a community hospital. Both white and colored residents contributed to the building fund. The board of directors is composed of sixteen members, eight white and eight colored, nominated for four-year terms so planned that half are chosen each two years. Four members are chosen by the county, four by the city, four by the Richardson family and four by the members of the board. The chairman of the board is a white physician. The chief administrative officer of the hospital, a physician, and all members of the nursing staff are colored. An active medical staff, white and colored, is elected by the board of directors, while membership in the visiting staff is open to any reputable physician who wishes to bring his patients to the hospital.

The L. Richardson Memorial Hospital is housed

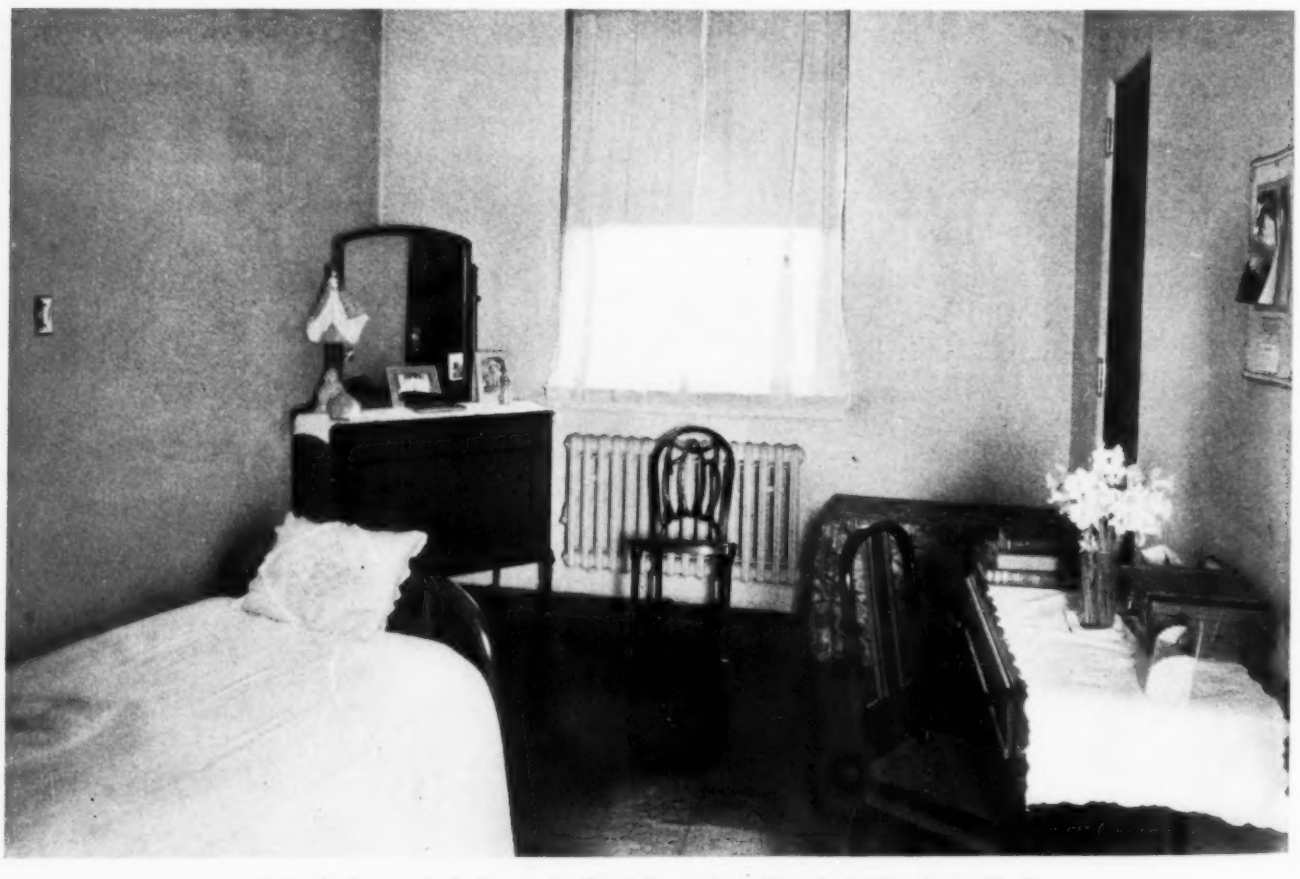
in modern fireproof buildings of brick veneer on hollow tile and reenforced concrete. The bed capacity is sixty-two, including two bassinets. There are four single rooms at $25 a week, four two-bed rooms at $21 and forty-eight beds in wards at $14. Plant, buildings and equipment are valued at $153,000. During 1930 the hospital gave 9,655 days of care to 934 patients at an average per diem cost of $2.58.

Negro Hospitals Are Increasing

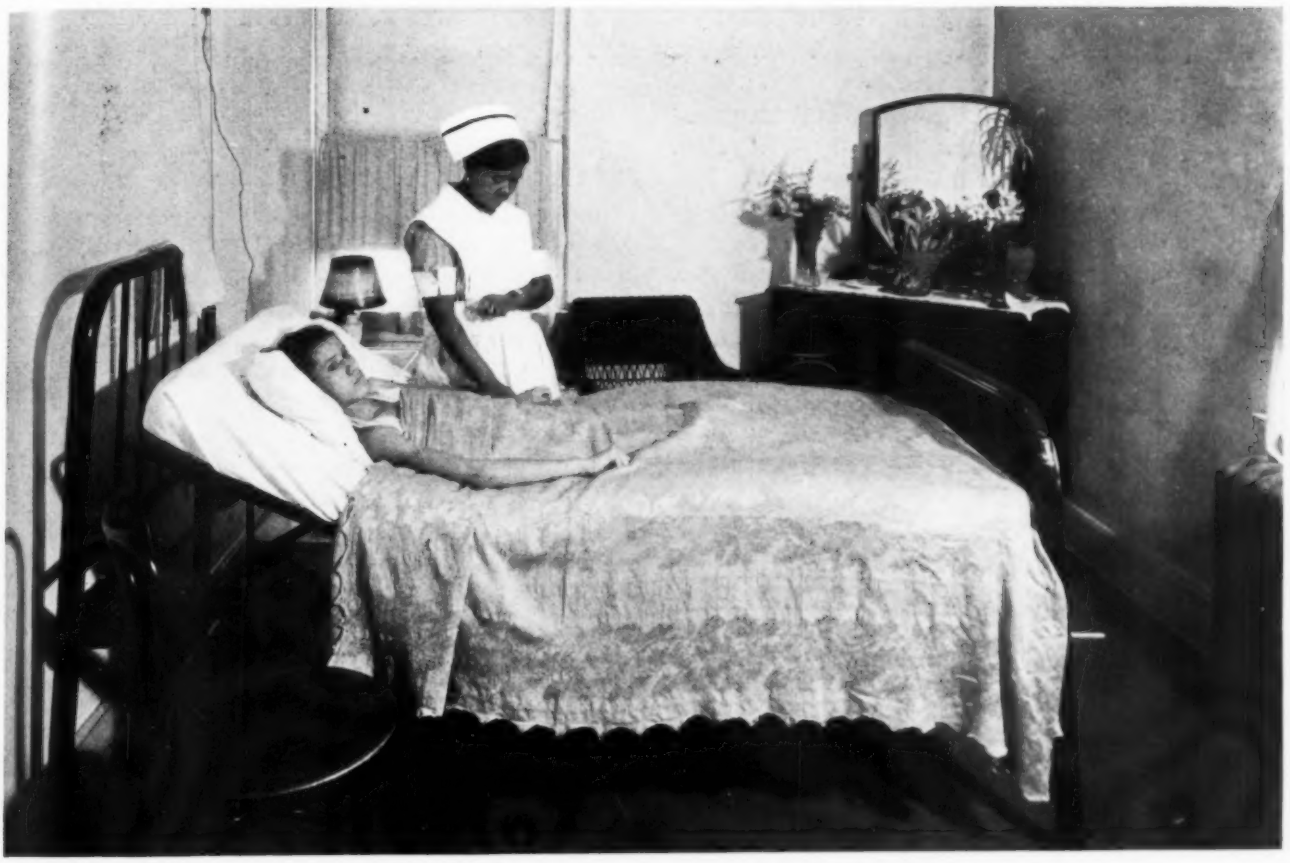
The nursing staff, including five registered nurses and nineteen nurses in training, is housed in a new building for which the Duke Foundation and the Julius Rosenwald Fund each contributed $17,000. The nursing school is accredited by the state board of examiners. Candidates for admission must have graduated from an accredited high school. One hundred fifty-six weeks of training are required, with eighteen hours of class and laboratory work during the first two years and twelve hours the third year. Student nurses receive an allowance of $2 a month the first year, $4 the second year and $6 the third year.

These three small general hospitals illustrate the best traditions of the South and of the medical profession. Though these particular hospitals care for Negro patients only, all three owe their success to the united interest of both white and colored leaders in the community and to the generous devotion of physicians of both races, who have worked to establish and maintain high professional standards. It is significant that though the two older hospitals represent the initiative of white missionary groups into which the colored participants have been drawn as their professional attainments qualified them, the more recently established Richardson Memorial has been from the outset a community hospital toward which both groups contributed and in which they share responsibility through board and staff representation.

These hospitals, however, are only three of a relatively small but growing group of general hospitals in the South which either care for Negro patients exclusively or make special provision for them. At Tuomey Hospital, Sumter, S. C., for example, half the bed capacity is contained in a building with private rooms and wards for Negro patients in which colored as well as white physicians may care for their private patients. Here, as in the other hospitals, provision has been made for out-patient service for Negroes. Four colored nurses are in training, under the direction of the white supervisory staff, which is in charge of the hospital's larger training school for white nurses.



A typical nurse's bedroom in Good Samaritan Hospital, Charlotte, N. C.



One of the private rooms in L. Richardson Memorial Hospital, Greensboro, N. C.

At Dixie Hospital, a seventy-five bed community hospital in Hampton, Va., there are wards, semi-private rooms and private rooms for both white and colored patients. Physicians of both races practice in the hospital and participate in staff meetings. The supervising nurses are white while the colored nurses in training are students in the recently established nursing school of Hampton Institute and must meet the college entrance requirement of the institute—graduation from a four year high school and academic standing in the upper half of the class. At the Spartanburg General Hospital, Spartanburg, S. C., the county maintains a building for Negro patients with forty-four beds and four bassinets, and a training school for Negro nurses in conjunction with similar services for white residents.

From the point of view of the whole community as well as its Negro members, developments such as these are of great importance, especially in the South. In spite of unusual progress in hospital building in recent years, North Carolina, in 1930, for example, had only a little more than half the ratio of general hospital beds to population obtaining in the United States as a whole (1.7 beds per 1,000 of population as compared with 3), according to the compilations of the American Medical Association. At the close of this same year the Duke Endowment reported that 19.8 per cent of the general hospital beds in North Carolina were available for Negro patients. Negroes constitute nearly 29 per cent of the state's population. This meant only one general hospital bed for each 840 of the Negro population, in contrast to one for each 592 of the general population of North Carolina and about one to each 334 of population in the United States as a whole.

Negro Physician Is Handicapped

In the South generally, hospital facilities for Negro patients are often entirely lacking in rural districts and in cities they are frequently limited to a few beds in a hospital basement or to a tiny, struggling, inadequately equipped, proprietary hospital which one or two Negro physicians have started in an attempt to gain some facilities for the sick of their race and a little opportunity for themselves. In this part of the country, Negro physicians are rarely received as members of hospital staffs except in hospital services which minister to their own race. Even when a room or ward for Negro patients exists, the Negro physician must either relinquish the care of his private patient, if he goes to the hospital, or must keep him at home without the facilities a hospital would afford. The lack of opportunity for the

Negro physician to develop himself in the specialties, particularly in surgery, and to have the advantages of cooperative professional work with other physicians is a great handicap and militates not only against the physician himself, but against the health and welfare of his whole group.

A Significant Development

These considerations render such institutions as have been described in this article of particular importance. They are hopeful signs of what, when the present period of financial depression lifts, may be a general advancement of hospitalization for Negroes in the South. Of unusual significance is the use of public funds contributed by local taxes to support Negro hospitals. Spartanburg, S. C., has been referred to as an example. In Columbia, S. C., is another. Knoxville, Tenn., has a unit for Negro patients now under construction as part of the Knoxville General Hospital, under a plan or organization which will admit the Negro physician to staff privileges both for free and private patients. Such examples as these are contributions not only to their own communities but to the country and to the professions at large.

New Flat Rate Hospital Charges Popular in Cleveland

The University Hospitals of Cleveland, placed in effect on August 1 a new system of all-inclusive, flat rate charges for hospital service.

"These rates are proving extremely popular and, because of the favorable reaction of the public to them, it is our belief that they will eventually have the effect of increasing our hospital occupancy," says John Mannix, asistant director, in commenting on the institution's new system of charging for services. Mr. Mannix's description of the plan follows:

The flat rates were arrived at by a study of charges for room and extra services made on the old basis. First of all, we grouped all our various types of accommodations into four classes—open division, semiprivate room, private room and private room with bath. Our open division rooms, which formerly were renting for $3.50 and $4 a day, were set up on a basis of $3.75 a day. The semiprivate accommodations, which formerly rented for $6, $6.50 and $7 a day, were set up on a basis of $6.25 a day. Our private accommodations, which formerly rented for $9, $10, $11 and $12 a day, were set up on a $10 basis. Our special private accommodations, which formerly rented for $13 and $16 a day, were set up on a $12.50 basis. Our reason for lowering the rate to this degree for the special private rooms was to increase the occupancy of this type of accommodation.

We then decided to average our former special charges for surgical, medical, obstetrical and pediatric patients and proceeded to make two primary groupings—first, surgical and obstetrical, where the extra charges averaged approximately $25 a case, and medicine and pediatrics, where the special charges averaged approximately $5 a case. The flat rates were set up on a basis of the average room rates as mentioned above, plus the average of the special charges. For example, the private room surgical case was set up on a basis of $10 a day for ten days' service plus $25 for special service, developing a flat, all-inclusive rate of $125 for ten days.

Flat Rate Is Optional

The tonsil and adenoid rate was set up on the basis of the new average room charges plus $5 when a local anesthetic is administered, and plus $10 when a general anesthetic is administered. The cystoscopic rate was set up on a basis similar to the tonsil and adenoid rate. The diagnostic service rates were set up on a basis of the average room rate plus $20 for special services. In this classification, however, we do not allow a refund when the patient remains less than the specified seventy-two hours.

At the present time these rates are optional; patients may choose the old system of billing if they desire. However, the great majority of admissions are being made on the flat rate basis, and it is our intention to discontinue the old room charge plus special service charges in the near future.

Psychologic Effect Is Good

We adopted this new method of charging because we felt that the old method wrongfully made hospital charges appear excessive on account of the uncertainty regarding the total amount of the charge. We feel that if we can present our rates in such a fashion as to induce patients to think in terms of a flat sum of money for an all-inclusive service, they will realize that present charges are not excessive.

Despite the fact that these rates are on the average only about 2 per cent less than the old rates, the general comment regarding them is that they evidently represent a considerable reduction as compared to the old basis. All of which goes to prove that the public's knowledge of hospital charges is based largely on hearsay rather than on acquaintance with facts.

The American Hospital Association and Its Future Program

A Paper From the American Hospital Association Meeting

By S. S. GOLDWATER, M.D.
New York City

THE critical spirit in the American Hospital Association has never been smothered or subdued by a flattering sense of achievement. On the contrary, the board of trustees has never ceased to call attention to the association's shortcomings. As the trustees and nearly all our presidents have viewed the matter, the measure of the association's failure has been the difference between the performance of hospitals as we know them—hospitals subject to the limitations of knowledge, of human character and of material resources—and the theoretical accomplishment of hospitals smoothly and gloriously functioning under the direction of supermen in a prosperous, enlightened and grateful world.

The Association's Aim

The association has always been eager to place on its own shoulders not merely the burdens of its members, but a considerable portion of the troubles of suffering humanity. For the unsatisfactory training of superintendents, for the ignorance of trustees, for the professional misconduct of the black sheep of the medical fold, for the undersupply or the oversupply of trained nurses, for the omissions and the blunders of legislators, for the unreasonable complaints of a misinformed public, for the lack of community hospital planning, for the uneven quality of hospital supplies, for the absence of retirement funds for hospital officers and for the dearth of medical service in rural communities, the association has unhesitatingly assumed responsibility and has expressed the determination or at least the willingness to heal every wound, to supply every want, to remove every irritating obstacle that lies in the path of hospitals striving for perfection.

I suppose that most of us at one time or another have been tempted to think of masterly achievements extending far into the field of hospital organization and administration as properly falling within the scope of the association. And since the constitution of the association defines our object as the doing of "all things which may best promote hospital efficiency," the organization cannot justly complain if eager and trusting members have looked to it, as a certain type of veteran looks to Washington, to make life effortless and enjoyable.

When the association was originally organized, the superintendents whom it brought together appear to have had in mind chiefly a closer personal acquaintance and the hope that an improved understanding of hospital problems might result from the interchange of experiences; subsequently the ambitions of the association rose, its members became more exigent. If anything needed to be done, the association was considered ineffectual if it did not immediately swing into action.

It has been suggested that the association provide a thorough training for hospital executives, that it furnish a variety of expert consulting services, that it determine the personal qualifications of candidates for executive positions, that it compel the states to adopt uniform laws, that it standardize hospital accounting, establish research laboratories, and create a nationwide system of health insurance; after which, presumably, the association might be permitted to suspend its labors until a changed world called for fresh efforts at investigation, education and reform.

There Is a Limit to Everything

You may think this picture overdrawn, but I have named only a fraction of the demands actually recorded at a conference called several months ago for the purpose of reviewing the activities of the association and considering its relations with state and regional bodies. Without attempting to appraise the merit of these suggestions, whose idealistic purposes I confess have my strong sympathy, it is safe to say that considered in

their entirety they represent, as was said of a recent novel, "a tale that couldn't have happened"; and the association's plan and scope committee felt that it would be wise to place a reasonable limit upon what it asked the association to accomplish.

Present Activities Are Numerous

Let us concede that theory must be translated into administrative practice before hospitals can become efficient. Does this mean that the association, efficiency's champion, may properly be asked to assume responsibility for the actual administration of hospitals and for creating and molding all of the social agencies by which hospital administration is affected? When the problem is stated in this way, the true size of the order becomes apparent and one begins to doubt the practicability of filling it. And yet we blithely charge the association with neglect of duty because it hesitates to undertake tasks that are appropriate to and are ordinarily assumed by universities organized for teaching, by civil service commissions skilled in the technique of examinations, by privately endowed research institutions and government laboratories commanding the services of scientific staffs, by legislative drafting bureaus learned in the law, by insurance companies with resources running into the billions, by community chests and by boards of hospital trustees. The association may and should collaborate with such bodies, it should stimulate and perhaps on occasion restrain some of them, but it can hardly be expected to supplant them.

Perhaps it will encourage us if we turn aside from the consideration of complicated tasks that the association has left to others, and examine its own present activities. The association is a going concern, and its activities, when you come to enumerate them, are found to be far from negligible. Briefly summarized, the current activities of the association are these:

1. The Convention, with its presentation and discussion of committee reports and individual papers in general sessions, in section meetings, at round tables and in joint meetings with other organizations; with its opportunity for wide personal contacts and its program of local hospital inspection.

2. The Exhibit, with its commercial and scientific departments.

3. The investigation of hospital problems by individuals and committees eliciting reports many of which have been characterized as masterly.

4. Cooperation with regional organizations, with national societies, with the International Hospital Association, and with various governmental agencies, illustrated by the appointment of delegates to the American Public Health Association's Committee on Care of Sick, to the American Conference on Hospital Service, to the Committee on the Grading of Nursing Schools.

5. Activities relating to current problems, such as veterans' hospitalization, hospitalization for colored patients, hospital relief in national or local emergencies.

6. Activities relating to legislation.

7. The Library, which has become a depository for a great mass of valuable reference material of which wide use has been made by members and nonmembers.

8. The Information Service, so unpretentious that its scope is realized only by those who are familiar with the routine of the central office.

9. The standardization of hospital supplies.

10. National Hospital Day, which has won widespread recognition, including the approval of the President of the United States.

11. Publicity work of miscellaneous character, directed by the central office.

12. The Bulletin, and the special Quarterly Magazine, to which many members make contributions.

13. The Transactions, the annual report of the scientific and business proceedings of the association, including a record of round table and other discussions, of reports presented and papers read at the convention and of the official acts of the association and the board of trustees—perhaps the most valuable publication of its kind in the world.

How to Profit From the Convention

No one, unless he were deaf, blind, indifferent or asleep, could fail to derive profit from participation in one of our great annual meetings; and yet many members go away from the convention feeling unrewarded. One member finds the general meetings too large and impersonal, another, that the section meetings are too numerous and confusing, a third, that the convention program is not sufficiently inclusive and a fourth, that it is bewilderingly overcrowded.

Now although no one person can possibly absorb all that the convention has to offer, it is consoling to know that a member can turn to the printed transactions for any important item that he has missed. The creation of numerous small round tables devoted to selected topics has been wisely recommended on many occasions as a method of increasing the opportunities for helpful discussion; this is a matter that requires no new legislation, and experimental changes of this

character are certain to be made from time to time as experience suggests. For the purpose of intensifying and systematizing discussion, there have already been created sections on administration, trustees, construction, nursing, dietetics, out-patients, social service, children's hospitals, small hospitals, teaching hospitals and tuberculosis. The advantage of these sections is that they facilitate personal contacts and the exchange of views among groups of members who are faced with the same problems, and the Transactions show conclusively that the sections promote progress.

Exhibit Is Education in Itself

The hospital superintendent in these modern times is required to deal with a multitude of problems. The questions that at a given moment press for answer in one institution are not necessarily those that demand immediate attention elsewhere. If the particular problem with which we are momentarily concerned finds a place in the convention program, we experience satisfaction; on the other hand, the program always disappoints some of us because of its failure to concentrate on some matter which for us as individuals is the question of the hour. To satisfy each member in this respect every year is more than can be hoped for, but by the systematic use of a continuous program chart successive program committees could probably achieve better results in the long range study of hospital problems than is feasible when each year's program is independently arranged.

The splendid exhibit which is a feature of the annual convention was originally known as a commercial exhibit; this term is no longer properly descriptive, for in addition to the varied and instructive commercial exhibit, whose value to individual institutions increases with the remoteness of the hospital from the larger commercial centers, the exhibit has in recent years included numerous features of a scientific, social, or noncommercial character. The two branches of the exhibit as we now know them are sometimes referred to as commercial and educational, but this terminology is incorrect because the commercial as well as the noncommercial exhibit has a distinctly educational value. It would be difficult to think of our great annual meeting unaccompanied by the splendid demonstration of equipment and supplies to which so many of our members look for guidance toward improved technique. If the association sees fit to adopt the recommendations of the plan and scope committee, its output of educational matter will be greatly increased and the noncommercial exhibit will be greatly enriched by the addition of material not now available.

Closer and more helpful relations between the American Hospital Association and the various state and regional hospital organizations are desirable. Views were exchanged on this subject at the conference held in October last between our board of trustees and representatives of provincial, regional and state associations. The October meeting was happily called the first annual conference, which implies the periodic joint meeting of this representative body and the eventual replacement of the existing loose relationship of the several organizations by one more clearly defined. We should not forget that although our affiliated organizations represent smaller geographic units they must be treated by the central organization as partners and not as obedient subjects.

In the enumeration of the association's activities I referred to our cooperation with certain national bodies other than hospital associations. With some of these organizations, such as the American Dietetic Association and the American Association of Hospital Social Workers, joint meetings have been arranged. With others, such as the American College of Surgeons, the American Medical Association and the American Nurses' Association, profitable joint meetings are scarcely practicable, and our relations, while cordial, have not been as close as might be desired. For although we may not be traveling in luxurious first-class cabins like our distinguished medical colleagues, or in tourist-third, which the nurses believe we are arbitrarily trying to assign to them, we are all in the same boat and we want it to be safely navigated.

The Activities of Other Groups

Some of you will recall that the American Medical Association, the American Nurses' Association, the Association of American Medical Colleges and other bodies joined with us some years ago to form the American Conference on Hospital Service, which sponsored and for a number of years conducted the Hospital Library and Service Bureau, and which set out with a much broader program. For reasons best known to itself, the American College of Surgeons declined to participate in this activity. It is nevertheless fair to say that the contribution of the College of Surgeons to hospital standardization has been a great boon, and that the college is entitled to our gratitude for its painstaking and fruitful efforts to raise professional organization and procedure to a higher plane. When the American Medical Association with its vigorous Council on Hos-

pitals and Medical Education embarked upon its program of hospital registration for the purpose of promoting the satisfactory training of interns, overlapping in the field of standardization was inevitable. The American Medical Association has precisely the same interest as the College of Surgeons in seeing that hospital staffs are properly organized, that staff members are qualified and of good repute, that laboratories are suitably equipped and manned and that clinical records are accurate and complete.

How the Best Results Will Be Obtained

It did not take long for the College of Surgeons to learn that while minimum hospital standards covering staff organization, staff restrictions, staff conferences, clinical records and diagnostic facilities were of prime importance to surgeon and patient, these measures were not in themselves capable of bringing about competent and trustworthy hospital administration. With its growing understanding of the nature of hospital organization we find the college gradually supplementing its basic standards by a variety of recommendations in which it sets forth its views concerning the organization of boards of trustees, the planning and equipment of laboratories and x-ray departments, the care of obstetrical patients, the administration of out-patient departments, the facilities necessary to ensure the prompt care of traumatic cases, the ratio of patients to nurses, the educational qualifications of undergraduate nurses, the management of the dietary service, an acceptable autopsy rate and the activities of the social service department.

The constant expansion of its list of recommendations is a tacit admission by the college that all branches of hospital service are interdependent and that a hospital survey cannot be entirely satisfactory unless it is comprehensive and complete. In other words, while the formulation of minimum clinical standards as originally conceived by the college was an epochmaking contribution to sound hospital practice, total efficiency in hospital administration can never be achieved by a program reflecting the restricted interests and aptitudes of the surgeon or the internist. There are criteria of hospital efficiency in regard to which it would be absurd to expect deep interest or full understanding from the busy clinician, and if hospitals are seriously resolved to set their house in order, they must learn to cooperate through the American Hospital Association because of its peculiar qualifications for dealing with hospital administration as a whole.

It is far from my purpose to suggest that the association or its members discontinue their cooperation with the powerful organizations to whose vigorous investigations, professional ideals and effective propaganda the hospitals of the country owe so much. Thanks to them, the hazards of happy-go-lucky hospital administration are now generally understood, and both the public and the medical profession have become intolerant of lax methods. Treatment of the sick is the very essence of the hospital's being and the function of hospital administration is to create conditions favorable for such treatment. To define these conditions in exact terms is to formulate a program for standardization. When we speak of standardization, however, we must not think of it as the permanent fixation of approved procedures (which would inhibit progress), but as the adroit manipulation of the financial resources, the physical plant and the personnel of the hospital in such a manner as to give free play to sound knowledge, to technical skill and to professional ideals. With this object in view, the great national organizations which are at work in the hospital field should agree among themselves to assign to each those tasks for which it is best fitted.

Continuity Needed in Association's Program

For many years our association, in its informal discussions and more especially in its committee investigations, has been attempting to formulate adequate administrative criteria, but our program has lacked coherence and continuity; the investigations of committees have had little relation to each other, and despite their variety and their merit, committee reports have failed to cover the hospital field in a systematic way. Reports containing helpful material, laboriously and skillfully prepared, have been published and almost immediately forgotten. In the meantime, as we have just seen, other organizations with superior generalship have proceeded to formulate standards for a limited number of specific hospital functions and have succeeded in getting these standards widely adopted. For a long time members of the association have looked upon hospital standardization and investigation or research as appropriate association activities. Gaps in the available material for standardization are patent, and if the association should ever seriously undertake the development of comprehensive administrative criteria, it would soon find itself forced to undertake the investigation of regions of hospital activity still unexplored.

The enrichment and wider use of the association's library are highly desirable and are receiving the attention of a special committee.

The replacement of the association's modest

monthly bulletin by a journal of ample content and superior quality is a hope dear to the hearts of many of our members; but this venture, however alluring, should not be undertaken without the backing of a guaranty fund to cover the operating deficit of the first few years. The urgency of the venture would be greater were there no other means of getting papers published, but this, fortunately, is not the actual situation. For official announcements the Bulletin is already available; the annual proceedings are fully reported in the Transactions and the various local, national and international hospital journals are only too eager to give a wide circulation to studies or announcements that are of general interest. So far as I know, no one has ever experienced difficulty in finding a medium for the publication of a really significant statement on a hospital problem. Some of our members have said that they would rather have their contributions appear in an official association journal than in any journal, however dignified and ethical, which is published under commercial auspices, but is it wise in such a time as the present to advocate a project the adoption of which would materially increase the association's financial burden?

In its study of the present activities and the future development of the association, the committee on plan and scope directed particular attention to the association's working methods, to what might be termed its stock of raw material and its machinery of production. The crude wealth of the association lies in the experience of its members; the critical analysis of these experiences by individual members or designated committees adds to their value, and it is by means of the wide circulation of the refined product of such analysis that the association strives to make effectual its contribution to hospital efficiency and hospital economy.

Committees Are Most Valuable Tool

The greater our membership (and incidentally, our present membership is numerically far from satisfactory), the greater the volume of experience to be studied and compared. The more complete the analysis of our combined experience, the greater the association's contribution to efficient administration. There is no limit to the number of investigations that can be conducted by individuals. When it comes to the investigation of a problem that can best be handled by a group, the association's practice is to appoint a special committee. Without intending any disrespect to the many members who have made creditable individual contributions to hospital literature, I think it fair to say that the association's committees have upon the whole proved to be its most valuable productive tool, for committees with clearly defined objects have almost invariably produced illuminating reports.

At the present time, several standing committees such as the public relations committee, the workmen's compensation committee, the committee on public health relations and the legislative committee, are concerned with phases of hospital work in which community relations are involved. The function of the standing committee on National Hospital Day is essentially that of popular education, and even in these distracting times the committee is doing a great work. The committees on planning and equipment, on organization and management, on bed occupancy, on fire insurance rates and on the standardization of supplies and equipment deal vigorously with varied aspects of hospital economy. The standing committees on clinical records and on autopsies are interested in the maintenance of high standards in clinical and scientific work. The work of these committees needs no encomium here.

Lack of Sustained Effort Noticeable

Comparable in value to the work of the committees now functioning (I have not attempted to name them all and of course no invidious distinction is intended) is that of numerous committees which, having completed their respective assignments, have quietly gone out of existence, leaving upon the record valuable reports which testify to the seriousness of their efforts but which unfortunately are not being followed up.

If, as I believe, the committee work of the association is its most valuable commodity, why not increase the volume and use of this commodity? Viewed as isolated efforts, the activities of investigating committees which have functioned in recent years have left little to be desired. Viewed in their entirety as a coordinated, balanced and continuous contribution to hospital improvement, the work of our committees presents a far less satisfactory picture.

There appears to be a widespread feeling among our members that although the association does some thinking and makes many gestures, it is weak and ineffectual in action. Now while it is true that there is too little done in the way of follow-up, I repeat that some of our demands upon the association are hardly reasonable. If a conference is called to discuss the work of the association, someone is certain to come forward with the demand that the organization take over, through the agency of expert field representatives, the direction of communal hospital affairs

in localities where hospital service is weak, while someone else will suggest that the association be ready to step in and reorganize individual hospitals that are conscious of their defects and are eager to reform.

Now while we who are hospital trustees and hospital superintendents may rightfully ask the association to contribute to our knowledge and to give us moral support, we cannot expect it to relieve us of responsibility for the management of our institutions. And I seriously doubt whether many of us would care to have the association take command of our private affairs. The proper function of the association is to learn, to inspire, to teach, to recommend, but not to administer the hospitals of the country, individually or collectively. The acceptance of this limitation of the association's activities would at once dispose of a large number of unreasoning demands upon the board of trustees which cannot be fulfilled, and would enable the association to concentrate upon the educational and inspirational services for which it is peculiarly fitted and which no other organization can supply in equal measure.

A Proposed Plan

If then, the influence of the association can be most effectually increased by the systematization of committee work and by making the results of this work cumulative, how is this to be done? What the plan and scope committee proposes is the organization of a group of permanent councils, composed of carefully picked members assisted by one or more paid secretaries, to initiate, direct and coordinate studies and investigations, to keep alive until practically applied the accepted findings of our own committees as well as the helpful recommendations of outside organizations that report from time to time their technical findings, and to act as authoritative reference bodies in assigned spheres.

In the field of hospital medical practice, for example, a carefully selected council appointed by the association could no longer be ignored by other organizations which have a legitimate interest in but are not entitled to usurp the functions of hospital administration. With the aid of this and other councils, suitably constituted, the association would be prepared, as it never has been in the past, to bring to bear the full weight of its interest in and knowledge of organized medical service, medical economics, nursing problems, vital statistics, accountancy, legislation and social planning.

The suggested councils should be composed of persons having expert knowledge who are willing to serve gratuitously. The method of appointment would provide for long periods of service with minimum annual changes in the councils' personnel. The councils would resemble to some extent expert groups, bearing similar titles, which have done so much to raise the American Medical Association to a position of eminence, authority and usefulness in the controversial field of medical practice. They would not replace existing sections or standing committees nor would they prevent the creation of additional sections or standing committees. On the contrary, they would soon bring to light the need of new committees to investigate problems heretofore neglected and thus would create fresh outlets for the abundant energies of our members.

How the Councils Would Function

One of the proposed councils might properly be called the council on community relations. This council, as I conceive it, would not undertake hospital surveys or assume responsibility for writing the hospital program of any given community, but would be prepared to demonstrate the value of local surveys, would thoughtfully examine existing survey material and would endeavor to improve the current technique of community hospital appraisal. Since its membership would include executives of ripe judgment, it would soon become an expert reference body in relation to the organization of municipal and district hospital groups. The council on community relations would be prepared to cooperate in the hospital field with local agencies which may hereafter seek to obtain community action on the recommendations of such bodies as the Committee on the Costs of Medical Care; it would define the principles underlying the public interest in hospitals, and would endeavor upon sound theoretical grounds to fix the respective limits of public and private responsibility. A field in which its influence would eventually be felt to the distinct advantage of hospitals and the public would be that of the many public relations of hospitals that are governed by law, for as part of its routine activity it would assemble and digest laws affecting hospitals and would give a powerful impetus to the movement for uniform state legislation.

In the department of hospital medical practice, the need of a permanent council is imperative. When medical men demand an influential voice in determining the conditions under which they are to participate in organized medical activities, the soundness of their claim is not open to question; but the medical fraternity must not forget that medicine would be unable to carry on more than a fraction of its present professional activities

without hospital support. The taxpayer and the philanthropic giver have placed at the disposal of organized medicine in this country, primarily for the public benefit, hospitals and laboratories representing a capital outlay of more than three billion dollars, and the productive employment of this huge capital is a matter of public as well as of professional concern.

The council on medical economics which the association is asked to create, should be made up of individuals qualified to consider from the community standpoint the questions of medical economics, theoretical and practical, which physicians and social theorists are constantly presenting from their respective viewpoints. The debate between those who advocate and those who oppose the expansion of organized medical services waxes warmer every day, but hospital administration has thus far failed to contribute its proper share to the discussion. Are physicians justified in protesting against the contribution of free service to ward and dispensary patients which they are forced to make in return for hospital privileges? If the voluntary hospital system is socially and economically sound, why the sudden demand that all free service rendered by voluntary hospitals be paid for by the government out of tax levies? If hospitals and clinics as now organized are capable of meeting the needs of the community, why the insistent call for a new hospital deal for the patient of moderate means? Is the group purchase of hospital service a practicable method of enabling the working classes to buy needed service which they now obtain at disastrous cost, accept unwillingly as a gratuity or do without?

Cooperation Is Needed

If new sources of income are presently to be made available for medical service through voluntary insurance schemes or by government action, how much of the available income should be assigned to hospitals and how much to physicians? When we reflect that the out-patient departments of New York City absorbed in a single year more than four hundred thousand new patients, presumably forced by economic pressure to abandon their family physicians and to seek gratuitous aid, the urgent need of intelligent social action in the sphere of medical economics is at once apparent. A mass movement of this magnitude does more than threaten the economic independence of the medical profession. Occurring without warning and without suitable adjustments in organization and equipment, it cannot fail to lower standards of treatment to such an extent as to jeopardize the public health. The American Medical Association has created a committee on medical economics to study and deal with questions of this character, but the American Medical Association and the public need our help.

I might go on to show in detail how an American Hospital Association council on nursing would give to hospital administration the influence which on the basis of expert knowledge of hospital practice and of public demands it is entitled to exercise in the organization of nursing; how it would disclose inaccuracies in oft quoted studies of the costs of nursing departments in hospitals of various sizes and types; how it would suggest the manner in which hospital wards should be arranged and equipped for the attainment of maximum nursing efficiency; how it would institute an inquiry into the relevancy of the standard nursing curriculum to hospital practice and community nursing needs. These are tasks which cannot satisfactorily be completed by investigators representing nursing organizations alone; they need our cooperation, as we need theirs.

Today's Supreme Task

It is easy to see the wonderful opportunities for useful service that are open to a council on hospital accounting and statistics. Is it not high time for someone to develop a single system of annual reporting sufficient to satisfy the legitimate needs of the College of Surgeons, the American Medical Association and the numerous state and municipal boards that exercise legal supervision over hospitals? Can one conceive of anybody better qualified to perform this task than a selected group of hospital administrators who know hospital work in all its ramifications? Superintendents know only too well that the existing methods of multiple reporting is a waste and a nuisance.

In the course of time the association might think it wise to institute a council on the economics of administration. This might well be considered by the trustees as a later step in the association's development. In the meantime the sections and standing committees on administration, organization and management, hospital construction and the standardization of supplies and equipment are functioning actively, and are not likely to neglect entirely any really important aspect of hospital economy, though each year's committee program must necessarily be a restricted one.

So far as the business activities of the association are concerned, no constitutional changes seem to be required except such as may be found

necessary to bring the association into closer relationship with state and regional groups. On the educational and scientific side the association has done a great deal of useful work, but its studies are not properly correlated and the only follow-up method thus far developed is the reiteration of recommendations at successive conventions. The association at present has no means, such as the proposed councils would supply, of bringing about the continuous and expanding application of conclusions derived from the study of its vast collective experience.

Is it rash to hope that the councils would do even more than organize and apply the knowledge we already have? How slight is our preparation for dealing with the fundamental problem of hospital support which has been thrust into the foreground by the present economic crisis! Of plans for the future support and development of community hospitals based upon a clear conception of social responsibility the association is almost guiltless. Our supreme task today is to assign the hospital its proper place in the social order. This can be done only by establishing sound relations between hospitals, physicians, nurses and the general public.

Needed Funds Can Be Obtained

As we approach this task we shall find in our path a veritable jungle of conflicting interests and confused ideas, and we shall make little progress unless we begin by fashioning for the association's use a new instrument, one with a sharper edge than any heretofore employed. It would be unreasonable to expect the councils to become such an instrument or to function with maximum efficiency unless they can command the services of full-time secretaries. I know full well that at the present moment the association is not in a position to add to its pay roll, but I have sufficient faith in the value of the proposed program to believe that its adoption will attract the favorable notice of public-spirited individuals or foundations that share our interest in the great problems of hospital administration and that from such sources, when business conditions improve, we shall succeed in obtaining the necessary financial support.

If the program of the plan and scope committee is adopted, members will be called upon to make new sacrifices to the common cause. It will be the privilege of those who respond to contribute with heart and mind to the further improvement of the American hospital which, with all its faults, is as nearly free from the taint of selfishness as any institution that our civilization has thus far produced.

State Hospital Watches Farm Costs With Accounting System

Taking advantage of the outstanding ability as an expert accountant of a patient in one of the farm colonies at the Jacksonville State Hospital, Jacksonville, Ill., a system of farm accounting has been inaugurated at that institution which enables it at all times to know exactly the financial status of all the various activities, according to Rodney H. Brandon, director, Department of Public Welfare, State of Illinois. All the books and profit and loss statements are accurate and complete in every detail.

The Jacksonville hospital operates a number of farms under leases. In this accounting system, each farm and each department is set up as a separate unit. All paid labor, feed and material used on the farm are charged against the operation, and credit is given for all commodities produced. No charge, of course, is made for patients' labor, that being considered a portion of their treatment.

As an example of the detail into which this accounting system goes, hogs in different stages of their development are carried on three different farms. When hogs at the proper age are transferred from one farm to another, one farm is given credit for the hogs moved and the other charged with the hogs at their weight on the date of the transfer.

The Boarding Home Program of Grasslands Hospital

A boarding home program has been planned at Grasslands Hospital, Valhalla, N. Y., for those patients who are chronically ill with tuberculosis, but who do not necessarily require a period of hospitalization.

Such a plan is the result of the demand for beds in the tuberculosis wards at Grasslands and the long waiting period for patients referred for hospital treatment.

The first boarding home, says the *Public Health Nurse,* is in an ideal location situated on seventeen acres of ground. The patients have their own apartment consisting of two sleeping rooms, a sitting room and porch. The boarding mother, who is particularly interested in her charges, has been emphasizing the home cooking and the men are as happy in their new surroundings as a group of school boys on a vacation. It is expected that the outdoor life and relaxation will speed the recovery of these patients.

New Wisconsin Orthopedic Hospital —Its Design and Equipment

By R. C. BUERKI, M.D.

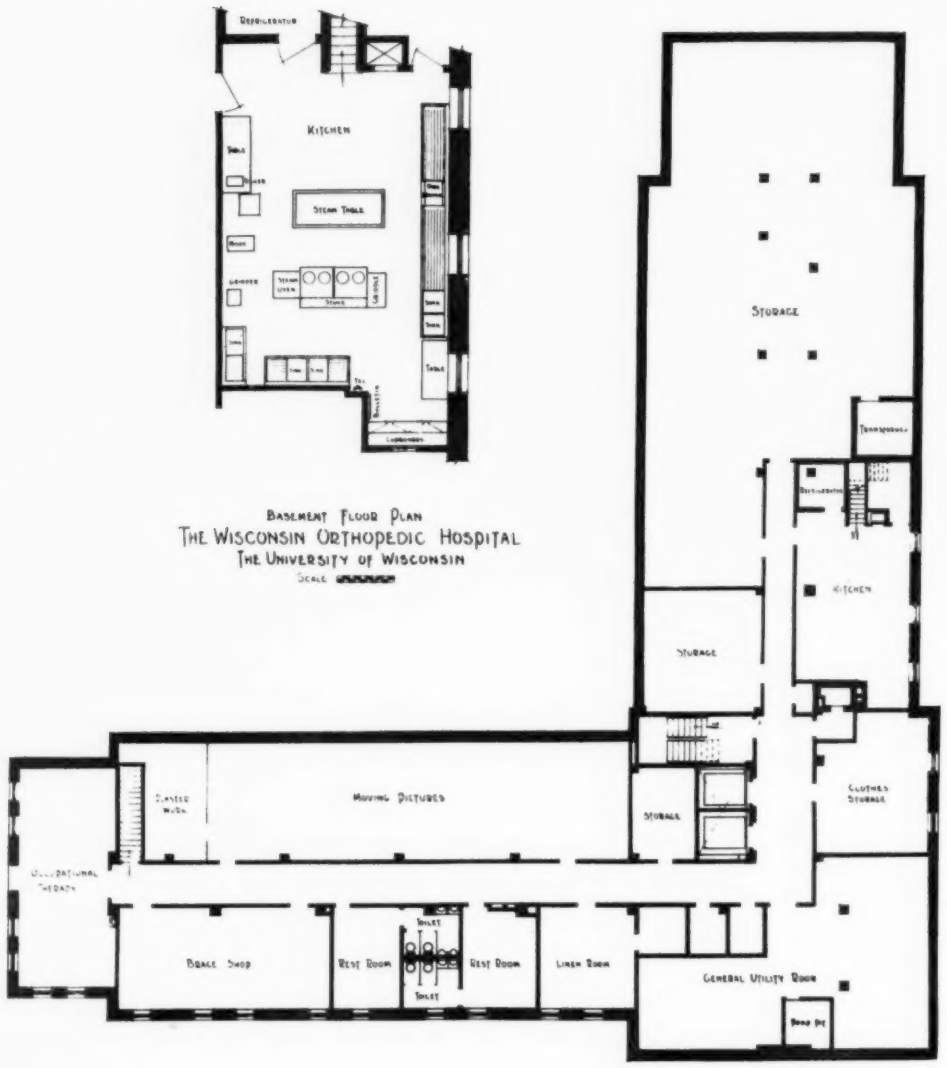
Superintendent, State of Wisconsin General Hospital, Madison, Wis.

AN ORTHOPEDIC hospital has been established on the University of Wisconsin campus, Madison, in conjunction with the State of Wisconsin General Hospital and the university's medical school.

The state legislature voted an appropriation of $300,000 in 1929 for building and equipping the hospital. It was built to care for all crippled individuals under the age of twenty-one years whose families reside in Wisconsin, and who otherwise would be unable to obtain proper care. Patients are sent to the hospital through the medium of the county judge, as joint state and county patients, the charge being borne equally by the state and the county. The teaching staff of the medical school renders professional services to the patients without additional cost to the state or the county.

The hospital is at the disposal of the medical school, for the teaching of medical students; the school of nursing, for the education of nurses; the department of physical education, for physical therapy and the department of sociology, for practical work in that field.

That Wisconsin has accepted its responsibilities in the care of the crippled child is attested by the fact that eight schools for crippled children have been established throughout the state in conjunction with the school systems of the respective cities. In these schools crippled children may receive physical and occupational therapy, in addition to their formal education. Supervision of these schools is centralized in the state department of public instruction and the teachers are paid directly from state funds, through the local board of education. The orthopedic hospital, therefore, is not required to keep patients in the hospital for long periods and can use these centers as clearing houses for the chronic cases or for those who might

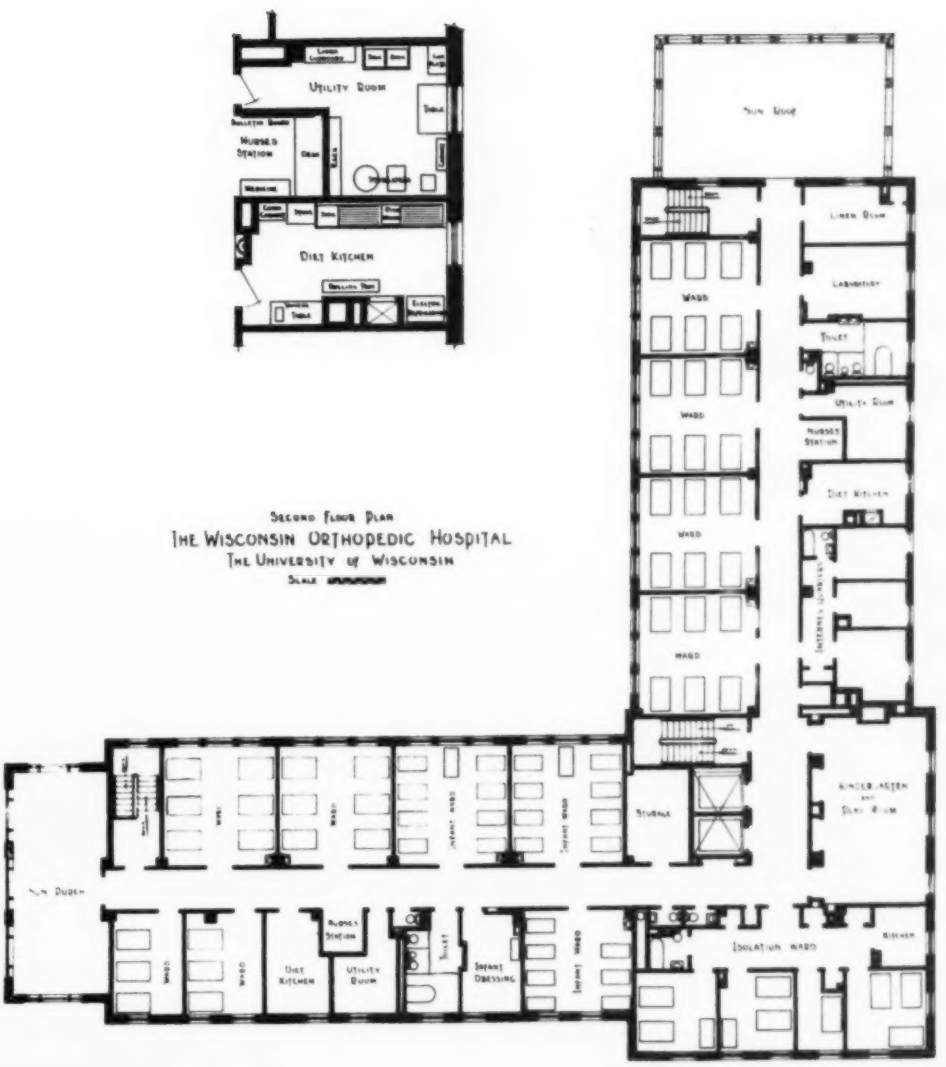


normally be cared for in a convalescent home.

The new hospital will accommodate 125 patients, and was opened on June 8, 1931. The central unit of the hospital is three stories high, from which extend, south and west, two two-story wings of equal size. There is a large, high ceiling basement under the entire building. Attached to the west wing is a one-story curative gymnasium, on the top of which is an open sun

The drawing at the top of the page shows the basement plan of the hospital. An exterior view of the new building is seen in the picture below.

A corner of the occupational therapy room is seen in the picture at the top of the page, while the sketch below shows the second floor plan.



Second Floor Plan
The Wisconsin Orthopedic Hospital
The University of Wisconsin
Scale

roof for patients from the second floor. The six-bed patient wards face south and west on a court that has a concrete ramp, upon which bed patients may be wheeled into the open air.

All wards and corridors are tiled to a height of four and one-half feet with a multicolored tile which not only gives the institution a pleasing appearance but also eliminates the need for frequent painting and patching of plaster. The idea of

using tile for the walls of corridors and wards was taken from the new orthopedic hospital, University of Minnesota, Minneapolis, and the tile used is similar to that in the schoolrooms of the Gillette State Hospital for Crippled Children, St. Paul, Minn. The floors of all wards and corridors are covered with rubber tile which eliminates noise and minimizes the cost of upkeep. The self-polishing wax used on the rubber floors has offered another saving in maintenance.

The hospital is divided into four ward units, but during the eight-hour night period from 11 p.m. to 7 a.m., the two units on each floor are combined for efficiency of service. Each ward unit contains a minimum of four six-bed wards. All of these six-bed wards face the center court and therefore receive a maximum amount of sunshine. All the wards have two large windows opening on the corridors and each two wards have two large connecting windows. This not only adds to the cheerfulness of the unit but also facilitates the ease of administration, both from a nursing and a disciplinary standpoint. Each of the sixteen four-bed wards contains a large picture, depicting some fairy tale or children's story. These pictures were painted by students in the art school of the University of Wisconsin.

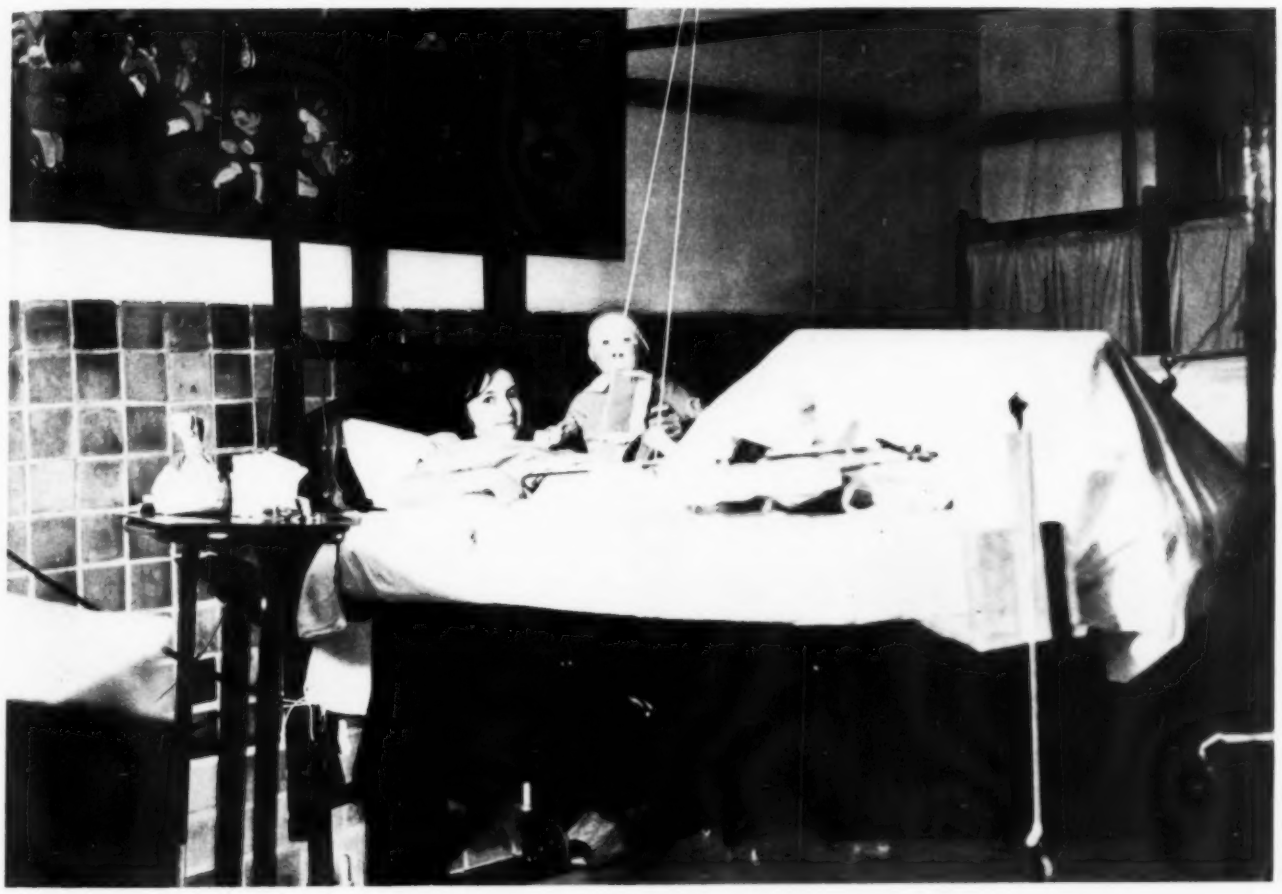
The nurses' station, in an inset off the corridor at the center of the ward, contains a charting desk with a built-in chart rack and a medicine cupboard with running water. On one side of the nurses' station is a utility room, and on the other side, a diet kitchen. The four utility rooms are the same throughout the hospital, but, due to structural changes, the diet kitchens vary somewhat in the arrangement of equipment. The utility rooms contain nickel-plated bedpan, instrument and utensil sterilizers. The bedpan rack, gas plate cupboard and work table are made of rustproof metal. All of these, together with a cabinet for the storing of general supplies, occupy a minimum amount of space.

Four offices for nurses and doctors open off the main lobby. The walls of the lobby are paneled with walnut and it contains period furniture, which gives the room an attractive appearance. The offices for physicians join the rooms where the out-patients are seen. This unit has in connection with it a portable x-ray unit for taking emergency pictures.

It was decided after considerable debate to place the kitchen in the basement, because of the noise and unsightliness of a kitchen adjacent to ward units. To the surprise and delight of everyone concerned, the temperature in the kitchen has never been excessive, thanks to an adequate ventilating system.

A small dining room, floored with black and green rubber tile, joins the serving and milk prep-

This drawing shows the arrangement of the main floor of the building. The curative gymnasium, sun porch and large sun ramp are valuable features of the design.



A section of a typical four-bed ward is seen in the picture at the top, while at the right is a reproduction of one of the art panels that decorate each of these wards.

aration rooms on the first floor. From twelve to fifteen of the ambulatory patients are served in this dining room.

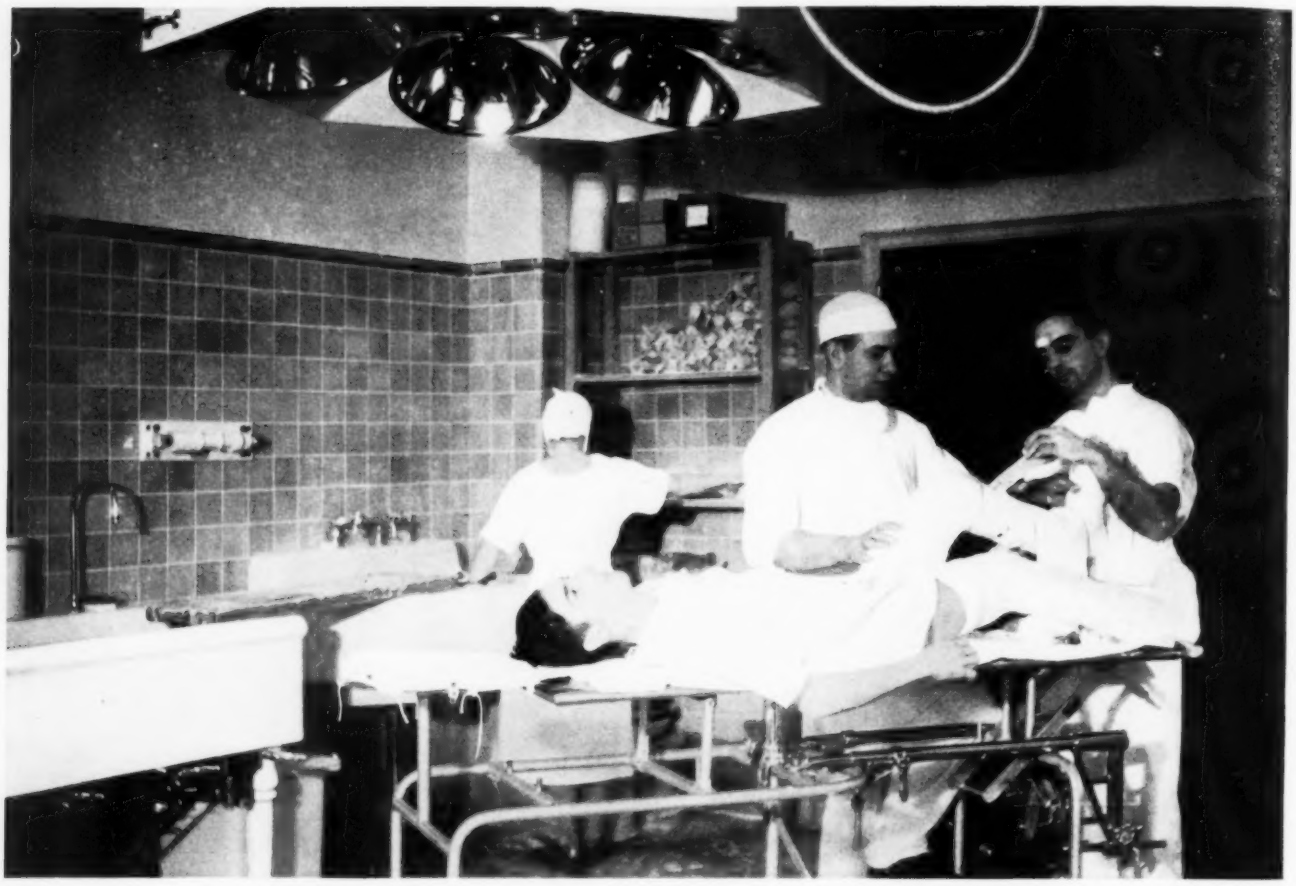
The curative gymnasium contains ultraviolet quartz lights and apparatus for physical therapy, in addition to parallel bars, rings, walkers and other apparatus necessary for rehabilitation. The walls of the gymnasium and tank room are of a yellow, hard surfaced, salt-brick tile. The therapeutic tank, elevated to a height of three feet above the floor, is a compromise between the large tanks at floor level in which it is necessary for the hydrotherapist to remain constantly in the water, and the small tanks in which the operator works entirely from the tank side. This room is equipped with a special tub for the more acute cases in need of hydrotherapy.

There are two classrooms allotted to education for those children who are able to be up and around. School is held for these children each morning. In the afternoon the teachers give bedside instruction. There is a library in conjunction with the school that is run by the children themselves. Two teachers, trained in bedside and informal instruction, are allotted to the hospital by the city board of education. This board, in turn, collects the salaries of these teachers from the fund set up by the state for this type of service.

There is a large attractive playroom and kindergarten on the second floor. The floor of this room is covered with two-tone brown rubber tile. The walls are paneled with walnut to a height of three feet and a fireplace at one end adds to the homelike appearance of the room.

A small suite of rooms is allotted to resident doctors in the hospital. This, however, is not adequate to care for all the residents and interns, some of whom are housed in the main hospital.

A ten-bed isolation unit cares for any acute contagion that may develop. This unit has its own



A section of the cast room in Wisconsin's new orthopedic hospital.

diet kitchen and sterilizing room and can be completely cut off from the rest of the hospital.

A branch of the main hospital laboratory occupies one of the rooms on the second floor. Only routine laboratory work is done here. All other work is sent to the central laboratory of the main hospital.

A large sun porch on the second floor and an open sun roof add to the cheerfulness of the institution. The sun porch is sometimes used as an overflow ward.

The third floor of the center section contains a large operating room and one "dirty" operating room. The walls of both rooms are tiled with a varicolored green tile. The floors are a gray-green terrazzo. Adjoining the operating rooms are a sterilizing unit and a supply room. A small dental unit, in charge of a graduate dentist, is also on this floor. In addition there is an x-ray room, equipped with a shockproof x-ray unit, where all routine x-ray work for the hospital is done.

The basement contains, in addition to the kitchen, storerooms, clothes rooms, heating units, rest rooms, a brace shop, the occupational therapy department and a moving picture room. Five mechanics are employed on a full-time basis to make all braces for the patients. The occupational therapy department occupies a well lighted and ventilated room. A large room originally intended for a storeroom, is now being used once a week for moving pictures, which are a source of great pleasure to the patients.

During the first six months of operation, the hospital has had an average census of 127 patients and has admitted a total of 529. It may also be of interest to note that during the recent poliomyelitis epidemic, which brought many patients to the hospital for treatment, the main laboratory of the hospital purchased over $5,000 worth of blood from patients who could demonstrate past poliomyelitis residuals. The cost was approximately $25 for 500 cc. of blood. The serum from this blood was sold at cost to physicians in the state. It was at first thought advisable to collect data as to the value of serum in the treatment of poliomyelitis. However, the control of the administration was not deemed sufficient to allow such research to be of real value. The concensus of opinion of the physicians of the state, however, is that the serum is valuable in the treatment of this disease.

The hospital has been found to fill a real need in state service in Wisconsin and we are particularly proud to have a building so well built and equipped at a total cost of $2,400 per bed.

Should Hospitals Go Into Business? —Some Say "Yes," Others "No"

FOR many years the question of whether or not hospitals should have drug and gift shops in connection with their institutions has been widely discussed. Because of the unusual conditions of the past year or two the question has again come up for even more serious consideration than before. Those in favor of the plan and those opposed to it both have definite opinions and logical arguments to support their contentions.

At the convention of the Western Hospital Association, held in Salt Lake City, Utah, in June, Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, reported on the situation.

In an editorial in the August issue of THE MODERN HOSPITAL, Dr. S. S. Goldwater, New York City, an eminent authority on hospital construction and administration, takes issue with the contention that hospitals should enter the commercial field.

One of the most interesting discussions at the Detroit meeting of the American Hospital Association was on this subject and many different views were expressed by those present.

In an effort to help clarify the situation, we are presenting herewith the opinions of several administrators of hospitals with different types of management, in different parts of the country. Opinions were sought from administrators whose hospitals do and do not have gift shops, and the geographic distribution was planned so that the various philosophies and traditions of locations could influence the opinions expressed. It is readily admitted that people in different parts of the United States are apt to think differently on the same subject.

We sincerely hope that other opinions will be forthcoming either for or against the inclusion of a gift shop and drug store in the hospital system.

Dr. F. A. Washburn, Director, Massachusetts General Hospital, Boston:

"Let the shoemaker stick to his last and the hospital director to the management of his hospital. If he does a good job at this it will take all his time and thought. He should not be diverted from it.

"Most hospitals are exempt from taxation as charitable institutions. It would, then, be necessary to consider very carefully this phase of the matter before entering into competition with other business groups in the community, who are compelled to pay taxes on their property. We should be careful not to give ammunition to the large group who feel that hospitals should pay taxes. This danger can be avoided, of course, by having the commercial building off the hospital grounds or by arranging in some way for it to pay taxes.

"The main point is to settle the matter not on the basis of the possibility of making a profit to help the hospital financially, but on the basis of what is best for the interest of the hospital in order to promote the services for which it exists. These services are the kindly, careful and scientific care of the patient, education in medicine and its allied courses, research in medicine and its kindred subjects, care of the public health and prevention of disease. The hospital administrator should always bear these objects of the hospital in mind, and he and his board of trustees must determine what shall be added to the hospital on the basis of whether or not the proposed addition will strengthen the efforts of the hospital to promote these fundamental objects.

"It might well be that a tax paying staff building across the street and off the hospital grounds would benefit the hospital. I believe such a building would be useful to the Massachusetts General Hospital and the Massachusetts Eye and Ear Infirmary. If these hospitals should ever erect such a building it will be because they believe that it is for their benefit to have the activities of their staffs centered at the hospital. It will be because they feel that to have the doctors' offices alongside the hospital would provide an out-patient department for the private ward, just as the hospital itself provides an out-patient department for the poor and perhaps a pay clinic for people of moderate means. The building would be erected because the hospitals feel that with all the activities of their staffs closely connected with the hospitals the latter would receive more of the doctors' time for the benefit of the charity patients. It would facilitate the hospitals' work in their other objectives of education, research and various forms of preventive medicine.

"The Massachusetts General Hospital has for many years maintained a drug store in connection with its out-patient department. The Massachusetts Eye and Ear Infirmary maintains an optician's department to supply glasses for its patients. These two activities do make a certain amount of money for the hospitals but they were not established for that purpose. They were established in order to save the patients' money, and the goods sold are priced with that in mind. They were also established as a convenience for the patients and to make certain that they received first-rate products.

"When I have seen in some hospitals flower stores and other commercial activities at the entrance I, personally, have not been favorably impressed."

John M. Smith, Superintendent,
Hahnemann Hospital, Philadelphia:

"You have raised an interesting question, that of the advisability of hospitals conducting commercial and other enterprises for profit, and I am glad to have the pleasure of discussing it.

"It it believed that it would be much better for hospital administrators and other organizations to devote their time entirely to the care of the sick and injured and to the improvement of that care under the direction of the professional staffs. The care of the sick and injured in hospitals covers such a wide range of activity and the requirements are so exacting that it might be difficult for the administrative personnel to render this service in a first-class way were part of their time diverted toward the conducting of business for profit. The demand for these stores is a result of business conditions, and since they are already showing signs of improvement we believe the interest in the business enterprises will decline within the next year or so.

"So far as Pennsylvania is concerned our hospitals are nearly all incorporated 'not for profit' and as such they are not permitted to pay dividends or profits to anyone in any way, in return for which neither the state nor the local community assesses any taxes whatever. In Pennsylvania, churches likewise pay no taxes, and the question of renting space in a church owned building free of taxes was raised a few years ago. The local government charged taxes against the building because offices were rented to business enterprises. The matter was carried to court and the final decision was that a tax free building must pay taxes on that part of the building which is used commercially. A worse feature, however, is that when shops have been started in hospitals in Pennsylvania (and recently this has occurred), those institutions have found themselves being severely criticized by local businesses. Unfortunately it is sometimes difficult for a hospital to have the good will of all the residents of a community and nothing should be done that would interfere with it."

Ada Belle McCleery, Superintendent,
Evanston Hospital, Evanston, Ill.:

"With a number of shops, hotels and office buildings going into the hands of receivers each week one concludes that business is finding the going just as hard as the majority of hospitals are finding it. Why should it be assumed that a business would succeed as a hospital venture when it fails under private management? Is not the situation largely one of grass appearing greener in the neighboring pasture?

"It is a well known fact that spiritual life is usually dead in a church that is supported by oyster stews. Would either professional or scientific spirit flourish in a hospital where the manager is also a shopkeeper?

"A hospital has one principal concern—caring for the sick. If this is done well it will take the full time of a qualified executive."

J. R. Mannix, Assistant Director,
University Hospitals of Cleveland, Cleveland:

"The University Hospitals of Cleveland are rendering many miscellaneous types of service. However, this is done from the standpoint of convenience to patients and personnel and not as a money making venture.

"The hospital leases space within the building for a news stand, barber shop and beauty shop. This lease is held by a barber who employs an operator for the beauty shop, a clerk for the news stand, cigarette and candy counter, and a newsboy and porter for the barber shop. These three shops do a business of approximately $1,200 a month. The barber is making approximately $65 a week for himself after paying his employees and paying the hospital $50 rent each month. The $50 received by the hospital does not quite take care of the housekeeping, maintenance, heat and light overhead for this space.

"The hospital also maintains three hotel rooms, which are rented to relatives of patients at a rate of $5 a day for one person, or $8 a day for two persons. Because of the irregular occupancy of these rooms, they represent a loss to the hospital. On the other hand, this service together with the services mentioned above are accommodations that

are necessary for the comfort of patients, relatives and visitors, and we believe that the slight financial loss resulting from their operation is justified.

"There has been in recent years a great deal of discussion regarding the building of office buildings for physicians on the grounds of general hospitals. The University Hospitals of Cleveland have for the past eight years provided offices, examining rooms and secretarial service in the hospital building for members of the full-time teaching staff of the university. These are provided, however, as a perquisite and no direct charge is made to the attending staff for their use. The university reimburses the hospitals for the maintenance of the space as well as for the secretarial service.

"The hospitals sell drugs to patients of the attending staff as well as to discharged hospital patients. These drugs, however, are sold at retail prices inasmuch as we have always felt that the hospitals are not justified in entering into competition with retail drug stores. By charging retail prices, we do not, of course, develop much volume and the profit to us is very slight.

"We also maintain a dining room for members of the attending staff, but the rates charged are on a cost basis. We do not attempt to make any profit on this service.

"On January 1, 1931, the hospitals adopted the policy of not maintaining any personnel except the nurses and the resident staff. Since that time we have operated two cafeterias, one for technical and clerical personnel and the other for help. Ordinarily there would probably be no reason why we should not make a profit on the two cafeterias, but because we have cut salaries approximately 20 per cent, we are operating these cafeterias on a cost basis. As a matter of fact, we have had a slight loss for the first seven months of 1932.

"We are now about to install two gasoline pumps on the hospital property. We are doing this principally for our own convenience as the hospitals own and operate ten automobiles. We shall sell gasoline, however, to personnel at a rate of one cent higher than our cost price which will enable us to meet our overhead. This will mean a saving of approximately two cents per gallon to members of the personnel.

"We operate a large laundry that has a capacity much greater than our present needs. We have been giving serious consideration to the possibility of rendering laundry service to some of the other hospitals in the city, especially the smaller institutions where the volume is smaller and their present equipment is inadequate. Because of the volume of our work we have a laundry cost of 25 per cent less than the smaller institutions in the city. At the present time we are supplying laundry service to the university on a cost basis. Of course we do figure interest and depreciation in our overhead.

"In this connection, we are dealing with several hospitals at the present time with a view to laundering their blankets. We have special washers, driers and carding machines for blankets which of course the ordinary small hospital laundry cannot afford.

"In connection with our laundry we also have a window shade cleaning plant. We have proposed to the other institutions of the city that we handle their window shade cleaning on a cost basis. The only advantage to us in taking care of these last three items is that as our volume increases we have a wider distribution of overhead, and this of course results in a saving to us by reducing our unit cost.

"I have described these facilities at some length because I believe most of them are rather new to the hospital field. However, I wish to caution other institutions from entering into any of these services without sufficient study of the particular needs of their hospitals. Personally, I am convinced that only institutions of from 400 to 500 beds or more can support most of these services, and I do not believe that any institution can hope to make much profit from any of them. I am inclined to believe that when all overhead is considered, an institution would be fortunate to break even on any of the above services.

"Another point that is worthy of a great deal of consideration in this connection is the fact that most hospitals are supported by the community and they are not justified, in my opinion, in competing with business organizations in other communities. On the other hand, I feel that the hospital is justified in rendering all services necessary for the convenience of its patients and personnel."

John C. Dinsmore, Superintendent, University of Chicago Clinics, Chicago:

"It seems to me that this problem, like most other hospital problems, does not lend itself to a categorical answer. The proper procedure would in each case depend upon the circumstances.

"For instance, if a hospital unit is very far from other stores and the establishment of this service in the hospital would not seriously affect other local merchants and would prove a real service to the patients and to the friends of patients, then I see no reason why the hospital should not engage in this service. However, if the establishment of service units would tend to reduce the already inadequate volume of business enjoyed by merchants

in the immediate vicinity, then I seriously question the desirability of engaging in these activities.

"In the University of Chicago Clinics the whole operation is broken down into the following: (1) hospital units with indirect and direct charges—indirect being steam, electricity, housekeeping and building maintenance, direct charges being salaries and supplies consumed directly by the department; (2) out-patient department with its direct and indirect charges, and (3) seventeen supplementary departments with their direct and indirect charges. Income is credited to each unit that produces income, and each unit has a budget covering both income and expense. Each supplementary department is headed by a competent manager, who is responsible for the professional and business administration of his unit. I see no reason why, on this basis, we cannot properly administer twice as many units with approximately the same total overhead cost and render more complete service to our patients and their friends, at an even lower cost.

"To sum it all up, I am for hospitals going into business when it is right and proper for them to do so and when there is a need for this additional service. I do not favor their going into business under any other circumstances."

J. B. Franklin, Superintendent,
Grady Hospital, Atlanta, Ga.:

"Tax supported, public, charity hospitals do not need to seek new fields for revenue. Money making adjuncts to such hospitals are, therefore, not compatible with the operation of the institution.

"But most private hospitals, not heavily endowed, do need more revenue. Not only do the drug store, flower shop, barber shop, beauty parlor and office building afford revenue, but they are also convenient and of service to the public. I can see no real objection to them. Therefore, I favor them."

Dr. Joseph C. Doane, Medical Director,
Jewish Hospital, Philadelphia:

"I have ever been of the opinion that no general statement could be made as to whether or not hospitals should enter into competition with business men of the community. The hospital that is conducted largely for profit by a group of physicians or laymen and that is willing and able to exist on the income derived from its activities, has the best right, it seems to me, to establish drug stores, instrument shops, office space, flower marts and restaurant and hotel facilities. Such an institution does not announce its willingness to accept free patients nor does it exist as a community institution. The purely private hospital is perhaps justified in taking the above steps.

"The community institution that depends on contributions has but one article for sale—efficient service to the sick. It does not expect to balance its books, except through contributions from persons in the community. From a purely business standpoint alone, it cannot expect those with whom it is contesting commercially to give of their profits in order that the hospital may continue as a competitor. Human nature finds it difficult to 'turn the other cheek' in this manner. It is somewhat of a question, too, whether hospitals that have usually been tax-exempt because they were conducted on a nonprofit basis, can continue to merit such favors from governing bodies if they go into business. The hospital should not continue to exist if it must be transformed into a department store."

George D. Sheats, Superintendent,
Baptist Memorial Hospital, Memphis, Tenn.:

"There is no doubt that the entering of hospitals into the commercial field can be overdone, but so long as they confine themselves to business enterprises necessary for the clientele of their institutions they are on safe ground.

"It has been proved a decided advantage to institutions to have their principal feeders or staff members have their offices in the same building. This naturally brings up the problem of providing restaurant facilities, which can either be operated by the hospital or leased. The latter is the more desirable.

"In order to make the building complete, the addition of hotel rooms and a drug store is necessary insofar as the demands of the hospital clientele are concerned. This, however, is as far as the institution should go, as these enterprises coordinate thoroughly and do not destroy one particle of professional or ethical atmosphere that an institution should have. Also, they are of such a nature as not to burden the administrator with additional duties, inasmuch as he has his initial physical equipment, power plant, building custodian, engineer and electricians.

"The administrator should keep in mind at all times that he is not in the commercial business for the sake of making money, and the only legitimate excuse for such an enterprise would be to enable his institution to care for its indigent sick. During these times an administrator who can say to his community that his institution is caring for its own and that the public will not be called upon for funds to make up a deficit at the end of the year is indeed fortunate.

"The advisability and success of such a unit have been proved from the standpoint of its tenants by one I have in mind that has been in operation for five years. It was opened 95 per cent rented and I have been told by staff members in this building that their practice has increased from 20 per cent to 35 per cent. Naturally, this has increased the number of patients admitted by this hospital. From the standpoint of other patrons of such a unit, there is no question but that it is a decided success.

"If the proceeds from such an enterprise are handled in the manner mentioned above, the monetary profit would be exactly nothing, net."

Rev. John G. Benson, Superintendent, Methodist Hospital, Indianapolis:

"The Methodist Hospital has the features mentioned in your recent editorial, including a drug store, barber shop, beauty parlor, flower shop, hotel, tea room and public library.

"The motive that brought these features into being in our institution was in no sense a profit motive. We did not feel that the operation of these services would add materially to our funds. We did feel, however, that such features of service would create new friends for the hospital and a favorable attitude toward it on the part of the community, which of course would result in material benefit sooner or later but not in immediate profits.

"It has been our conviction that in order to render the best service to the sick, every effort should be made to imbue the institution with a community spirit. The sense of isolation and separation from society is as a rule very strong in the patient and anything that can be done to maintain his normal impression has a therapeutic value. It has been our experience during the several years we have had these features that the drug room, which is just off of the lobby, is a delightful social center for waiting friends as well as a place where various needs of the patients can be easily and quickly met without the need for leaving the building. For these and many other reasons we have gained the hearty approval of doctors, patients, trustees and friends who have witnessed the center in action.

"The hotel and tea room is also a service feature of inestimable value to the hospital. Friends of patients, convalescing patients desiring to cut hospital expenses, visiting physicians from the country and others find this department most satisfactory. The tea room furnishes a contact point for the interested public that results many times in gifts and offers of service to the hospital.

"The barber shop and beauty parlor represent an obvious service value far beyond any commercial consideration. Nothing is more damaging to the spirit of the hospital than visiting barbers of a talkative nature, or 'babbling bees' from neighborhood beauty parlors that have no official connection with the institution. In addition, the charges for service are lower than in the neighborhood shops.

"All these features when presented as a unit complete a picture of the hospital objective that is far more favorable than the picture once existing in the minds of the public.

"It is quite true that these features have financial value, but it is not of sufficient size to warrant their being brought into existence. The financial benefit is strictly secondary. I would not go into these ventures for purely commercial reasons. It is my conviction that those who look at this question from a purely business point of view miss the real reason that makes them necessary. To illustrate, a few years ago the Methodist Hospital was given a 168-acre farm, within six miles of the hospital. The farm was placed under the immediate direction of the purchasing agent and the dietitian and this year the hospital is reaping the benefits of the produce of the farm. We do not know yet whether this is a paying venture. We do not care. Our patients receive their trays with the knowledge that the food being served was raised on the hospital farm and it is a feature of our service that is worth all it costs. There is no doubt but that it will be a great help to the hospital.

"Hospitals, in our opinion, must be humanized. The public demands it. They must be made to fit into the lives of those who come to make use of their services. The technique for doing this is obvious. The patient finds himself at home, as do his friends, in these community surroundings and as a result many mental hazards are immediately wiped out.

"I agree with Doctor Goldwater in his attitude upon this subject when the motive is one of business and when these features are looked upon as commercial ventures designed only to help out a depleted budget. But if the motive is service, as it honestly is in our case and I think in a good many other cases, then I think that Doctor Goldwater misses the point entirely. When service to the patient is the prime motive there is no diversion of attention by the administrator. No more business acumen is needed for the running of a drug store or a barber shop than for any other feature of the hospital, and money must be found somewhere to pay for the whole hospital program.

"When the best kind of service is rendered by

an institution, that institution will profit eventually. Personally, I favor the introduction of any and every kind of service that will make more complete the therapeutic experience of a patient while he is in the hospital. If these features happen to be financially profitable, all well and good, but I doubt whether any feature, however necessary, should have as its motive profit alone."

Robert Jolly, Superintendent,
Memorial Hospital, Houston, Tex.:

"I am highly in favor of hospitals adding profit bearing accessories to their institution. Of course every institution has to be handled in its own manner. I have seen many hospitals that I felt perfectly certain could earn a nice profit in a drug store, while I have seen others I did not believe ought to undertake such. The same is true concerning gift shops, dining rooms and other such ventures.

"This hospital for a number of years has had a drug store, a beauty parlor, a barber shop and a dining room, all of which have been profitable. In one day, recently, we took in $22 in our dining room. In the past few months the drug store has made the difference between red and black ink for us. If I could figure out some other accessory income I certainly would do so.

"Not only do such accessories help to wipe out deficits, but they are a real benefit to the patients, visitors and personnel, saving much time and inconvenience and creating a fine feeling toward an institution which is evidently concerned about the comfort and convenience of the sick and the well.

"I have never seen any tendency for these auxiliary services to destroy the scientific and professional aspects of the hospital and see no reason why they should. We have just as many people looking after the sick and have just as high standards to maintain. I see no incompatibility here.

"When we first began this policy there were some who looked askance and perhaps criticized, but that was to be expected. Any innovation brings forth criticism. Any criticism directed at us was of short duration and I never hear any more of it. I am certain of one thing and that is, the patients and their friends, the trustees and our personnel approve of our policy in this matter.

"The management of these enterprises does not take away any time from the hospital management. A good hospital superintendent will departmentalize his hospital and place someone in charge of each department. The superintendent will supervise these department heads. We have a man in charge of our drug store who receives a salary and a commission. Our beauty parlor is operated on a salary and commission basis. The barber shop is handled on a straight rental basis. No hospital superintendent can manage every detail in a hospital. He must have subordinates to do this for him.

"There may be the criticism that the operation of these auxiliaries is a sort of speculation. Well, perhaps it is a speculation to begin with, but it certainly has proved profitable to us. However, I cannot see the difference in speculating in this sort of way and speculating with endowment funds. Hospitals that have endowments invest the endowment in stocks and bonds, the income from which is to make up deficits. If stocks and bonds are not speculations, what are they?"

Some New Features in Operating Room Design

A series of operating rooms, wherein a complete humidifying system has been installed to reduce the danger of explosions of anesthetic gases and to create the most favorable atmospheric conditions for both patients and workers, is described in the report of the American Hospital Association's committee on hospital planning and equipment, presented at the Detroit meeting. The rooms were designed by one of the members of the committee.

Floor grids have been successfully laid in a tile floor and to guard further against electric sparks, all of the electric switches are of the "mercury" type. In an attempt to find a reasonably comfortable seat for the spectators' gallery, a manufacturer of pedestal lunch counter seating was called in, and he proved his versatility in providing the proper article, which is believed to be an improvement over former types.

An x-ray shadow box was built in flush with the wall of each operating room. This box has a special lighting arrangement that provides good illumination, a feature difficult to obtain in built-in shadow boxes because of their necessary shallowness.

The mechanical ventilation system is connected to the various operating rooms in such a manner as to carry off stale air without creating strong air currents. Flushable floor drains have been used, a practice condemned by some, so as to make possible the use of large amounts of water in cleaning the floors. There are both compressed air and vacuum outlets in each operating room. A piping system for distribution of anesthetic gases was considered for the rooms but it was not installed.

Mechanical System Lends Speed and Accuracy to Bookkeeping

By J. J. WEBER
Superintendent, Vassar Brothers' Hospital, Poughkeepsie, N. Y.

IN HOSPITAL accounting probably no two items appearing on the balance sheet are more important and should receive closer attention than Cash Receipts and Accounts Receivable. And yet with us, as in all likelihood with many other hospitals, these were the weak spots in our accounting system.

The form in which our accounts receivable were kept—the detailed records of the patients' accounts being arranged alphabetically and the controlling accounts in the general ledger being arranged as to classes of patients and work—made it necessary for the bookkeeper to go through five accounts receivable books at least seven times to take off a trial balance of each classification. It is evident that even if this cumbersome method were used (which it was not), the opportunity for errors through copying the wrong balances or placing balances under the wrong classification is always present.

Bookkeeping Machine Reduces Errors

Two ways were open to us to overcome these difficulties and to accomplish the results we desired. We could either reorganize our accounting department and adopt a more definite plan of handling our accounts receivable records or we could utilize mechanical bookkeeping equipment. Should we adopt the first method we should have to employ an additional clerk in order that the bookkeeper might devote all her time to her own work. This

Section of main office showing bookkeeping machine and two-drawer cash register.

Date: June 23,1932

DAILY SERVICE REPORT — VASSAR BROTHERS HOSPITAL — X-RAY DEPT.

Number	Name and Address	Part	Films	No.	Doctor	O. H.	Remarks	Filter Check
45225	Mrs. Ada De Vine Corr 3	G.B. G.I.			GCMc	2.50		
45226	Marie Constantino Highland, N.Y.	R.wrist	1o		DN		Clinic	
45227	Mrs. M. M. Friedman 1 Manitou Avenue	Dental			Vmf			
45228	Mr. Jacob Ostrow 20 Manitou Avenue	Treatment						
45229	Arthur Craddock Ward 1	Treatment			JTH			
45230	Richard Stokes 17 Academy St.	Spine	8a		GCL			

Form MH-56-1

Fig. 1. A reproduction of one of the daily service reports or charge slips.

plan would eliminate many of our difficulties and make it possible to reconcile the details of patients' accounts with the control account in the general ledger. The human element, however, would not be removed. The reconciliation, involving approximately 2,000 accounts, would have to be done some time after the first of the month and there would be abundant opportunities for various errors to creep in.

By the use of a bookkeeping machine we felt that errors would be reduced to a minimum, the details of accounts receivable would be automatically in balance with the control accounts daily, each patient's bill and ledger card would give the correct balance immediately after posting each charge or credit and all charges would be recorded on the general books within the period in which they originated.

Having in mind these considerations, we decided to have a machine built for us that would post the patient's ledger card, print the entry on the patient's bill and make the distribution on the appropriate journal sheets all in one operation. This posting machine is supplemented by a two-drawer cash register, the drawers being marked A and B. This cash register enables two clerks during the regular business hours and two clerks during the balance of the twenty-four hours of the day to receive cash payments and be held responsible for what they receive. The amount of cash they place in their envelopes each time they clear the machine must correspond with the total amount recorded on the machine's tape.

In the main the earnings of the hospital are divided into three principal divisions: (1) earnings from private and semiprivate patients; (2) earnings for services rendered ward patients, and (3) earnings for services rendered out-of-the-house patients (not out-patients). There are, of course, incidental earnings from our out-patient department, our accident room and from the sale of supplies.

The method of posting this income is as follows: A daily charge slip (Fig. 1) is made up by each department showing the name and address of the patients and the amounts charged for the work. These charge slips are delivered to the bookkeeper by 8:30 each morning and become the posting media for all patients' accounts.

With these sheets before her, the bookkeeper

DN | NN | MON. ST. | TUES. L. # 1 | WED. L. # 2 | THURS. L. # 3 | FRI. SPEC. | SAT. SPEC. | SUN. SPEC.

VASSAR BROTHERS HOSPITAL
POUGHKEEPSIE, N. Y.

NAME DE VINE ADA MRS. — NUMBER 54463
ADDRESS SALT POINT, N.Y. — CLASSIFICATION SURG.
BILL TO WILLIAM J. - HUSBAND — LOCATION SP316
ADDRESS SAME — RATE $5.50
EMPLOYER
ADMISSION DATE JUNE 15, 1932 — TIME 10.45 A.M.
DISCHARGE DATE — TIME

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE
JUN 22 32	X-RAY	25.00		25.00
JUN 22 32	HOSPITAL SERVICE	38.50		63.50
JUN 22 32	NURSES BOARD	2.00		65.50
JUN 24 32	PAYMENT		65.50	0

DN | NN | MON. ST. | TUES. L. # 1 | WED. L. # 2 | THURS. L. # 3 | FRI. SPEC. | SAT. SPEC. | SUN. SPEC.

VASSAR BROTHERS HOSPITAL
POUGHKEEPSIE, N. Y.

NAME CRADDOCK ARTHUR — NUMBER 54327
ADDRESS COUNTY HOME BEACON, N.Y. — CLASSIFICATION
BILL TO CITY OF BEACON — LOCATION Wd 1
ADDRESS — RATE $4.00
EMPLOYER
ADMISSION DATE JUN 21, 1932 — TIME
DISCHARGE DATE JUN 22, 1932 — TIME

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE
JUN 22 32	HOSPITAL SERVICE	44.00		44.00

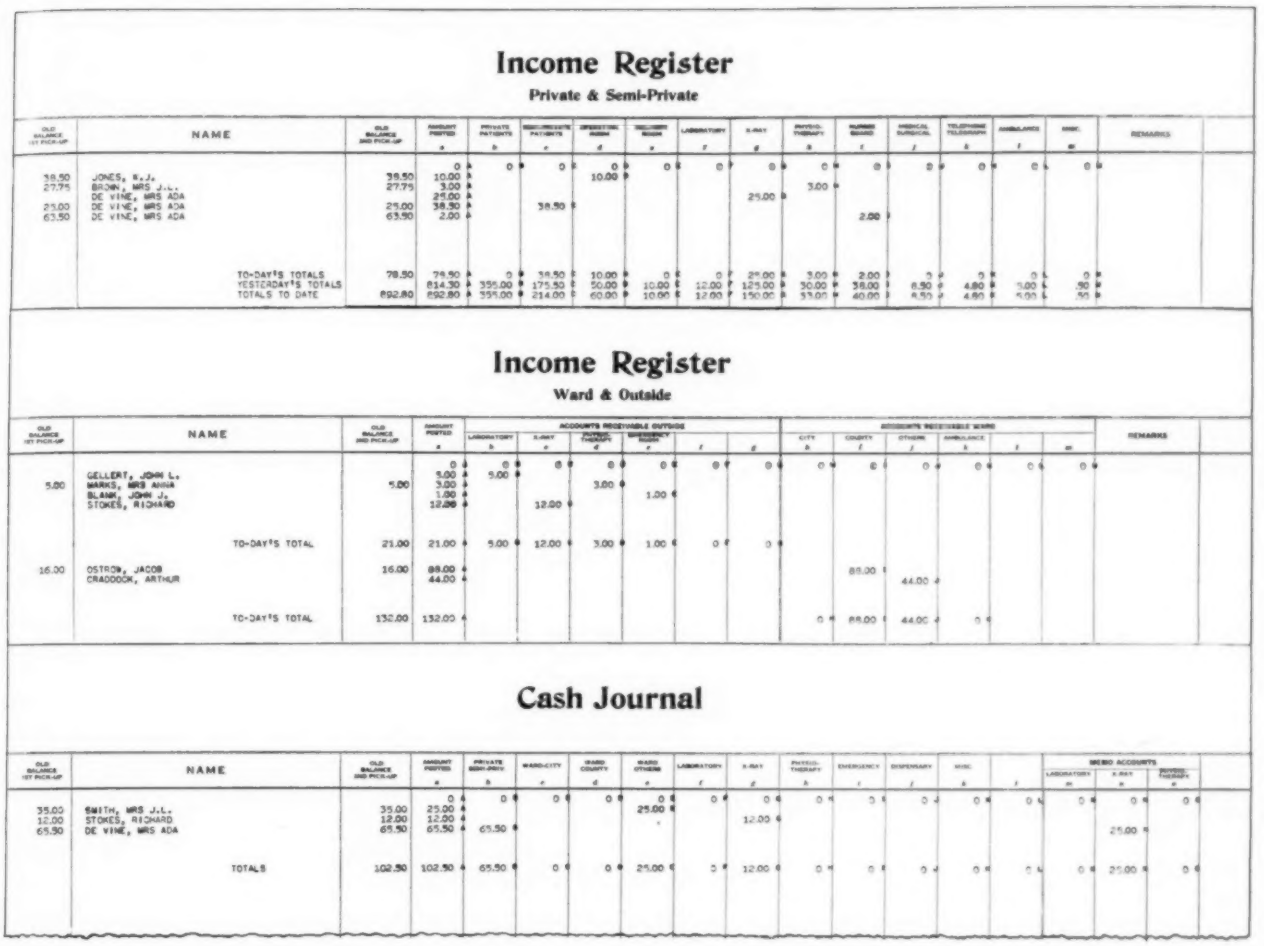
ST. | L. # 1 | L. # 2 | L. # 3 | SPEC. | SPEC.

VASSAR BROTHERS HOSPITAL
POUGHKEEPSIE, N. Y.

NAME STOKES RICHARD
ADDRESS 17 ACADEMY ST.
EMPLOYER
BILL TO
ADDRESS

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE
JUN 22 32	X-RAY #45230	12.00		12.00
JUN 24 32	PAYMENT		12.00	0

Fig. 2. At the top is a sample of the buff colored ledger card used for private and semiprivate patients. In the middle is a reproduction of the white ledger card used for ward patients. A sample of the blue ledger card used for out-of-the-house patients is shown at the bottom.



Income Register

Private & Semi-Private

OLD BALANCE 1ST PICK-UP	NAME	OLD BALANCE 2ND PICK-UP	AMOUNT POSTED	PRIVATE PATIENTS	SEMI-PRIVATE PATIENTS	OPERATING ROOM	DELIVERY ROOM	LABORATORY	X-RAY	PHYSIO-THERAPY	NURSES' BOARD	MEDICAL SURGICAL	TELEPHONE TELEGRAPH	AMBULANCE	MISC.	REMARKS
			a	b	c	d	e	f	g	h	i	j	k	l	m	
38.50	JONES, R.J.	38.50	10.00	0	0	10.00	0	0	0	0	0	0	0	0	0	
27.75	BROWN, MRS J.L.	27.75	3.00							3.00						
	DE VINE, MRS ADA		25.00						25.00							
25.00	DE VINE, MRS ADA	25.00	38.50		38.50											
63.50	DE VINE, MRS ADA	63.50	2.00								2.00					
	TO-DAY'S TOTALS	78.50	78.50	0	38.50	10.00	0	0	25.00	3.00	2.00	0	0	0	0	
	YESTERDAY'S TOTALS	814.30	814.30	355.00	175.50	50.00	10.00	12.00	125.00	30.00	38.00	8.50	4.80	5.00	.50	
	TOTALS TO DATE	892.80	892.80	355.00	214.00	60.00	10.00	12.00	150.00	33.00	40.00	8.50	4.80	5.00	.50	

Income Register

Ward & Outside

OLD BALANCE 1ST PICK-UP	NAME	OLD BALANCE 2ND PICK-UP	AMOUNT POSTED	ACCOUNTS RECEIVABLE OUTSIDE: LABORATORY	X-RAY	PHYSIO-THERAPY	EMERGENCY ROOM			ACCOUNTS RECEIVABLE WARD: CITY	COUNTY	OTHERS	AMBULANCE			REMARKS
			a	b	c	d	e	f	g	h	i	j	k	l	m	
	GELLERT, JOHN L.		5.00	5.00												
5.00	MARKS, MRS ANNA	5.00	3.00			3.00										
	BLANK, JOHN J.		1.00				1.00									
	STOKES, RICHARD		12.00		12.00											
	TO-DAY'S TOTAL	21.00	21.00	5.00	12.00	3.00	1.00	0	0							
16.00	OSTROW, JACOB	16.00	88.00								88.00					
	CRADDOCK, ARTHUR		44.00									44.00				
	TO-DAY'S TOTAL	132.00	132.00							0	88.00	44.00	0			

Cash Journal

OLD BALANCE 1ST PICK-UP	NAME	OLD BALANCE 2ND PICK-UP	AMOUNT POSTED	PRIVATE SEMI-PRIVATE	WARD-CITY	WARD COUNTY	WARD OTHERS	LABORATORY	X-RAY	PHYSIO-THERAPY	EMERGENCY	DISPENSARY	MISC.		MEDICO ACCOUNTS: LABORATORY	X-RAY	PHYSIO-THERAPY
			a	b	c	d	e	f	g	h	i	j	k	l	m	n	o
35.00	SMITH, MRS J.L.	35.00	25.00	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12.00	STOKES, RICHARD	12.00	12.00				25.00										
65.50	DE VINE, MRS ADA	65.50	65.50	65.50					12.00							25.00	
	TOTALS	102.50	102.50	65.50	0	0	25.00	0	12.00	0	0	0	0	0	0	25.00	0

Fig. 3. The income register for private and semiprivate patients is a blue colored card similar to that at the top of this illustration. In the middle is a reproduction of the buff colored income register for ward and outside patients. A sample of the white cash journal sheet is reproduced at the bottom.

pulls the patients' ledger cards for all charges against private and semiprivate patients; she also pulls all cards that are to be billed weekly for hospital service and special nurses' board. These cards are located by means of tabs at the top of the cards. For example, the card of Mrs. Ada DeVine (Fig. 2) indicated that she was admitted at 10:45 on the morning of the fifteenth, which was Wednesday. When the card was made up a tab was placed over the space marked "Wednesday" at the top; the rate shown is $5.50. On Wednesday, the twenty-second, this patient was billed for a week's service at $38.50 (Fig. 4). When all of these cards have been pulled the bookkeeper figures the hospital service charges for each patient and then lists the charges on a scratch pad. This list serves as the posting medium for these charges, including special nurses' board which is figured from the days marked on the chart at the bottom of the card.

The next step is to head patients' ledger cards for all patients admitted during the past twenty-four hours. This information is obtained from a slip submitted by the admitting clerk. This slip contains all the information needed to fill out the heading of both the patient's ledger card and his bill. At the same time a list of the patients to be discharged that day, insofar as this information is available, is obtained from the admitting clerk and their cards are pulled and the service charges figured and entered on the work sheet.

How the Posting Is Done

When all of this work has been done, the bookkeeper is ready to do her posting. The Income Register, Private and Semiprivate, is inserted in the machine and charges are posted from the daily charge sheets and the work sheets on the hospital service. Direct proof is used; picking up the old balance a second time and sub-balancing in the Amount Posted column and balancing out in the proper distribution columns. For example, the daily service report (Fig. 1) shows that on June 22, Mrs. Ada DeVine, a house patient (so identified by the charge listed in the column marked H on the daily service report) had some x-rays taken for which she was charged $25. On June 22 a charge of $25 was entered on her bill (Fig. 4). The same operation entered the charge on her

ledger card (Fig. 2) and on the Income Register, Private and Semiprivate (Fig. 3), where it was distributed to the x-ray column (g).

When all charges have been entered, the posting medium is all turned over to another clerk who makes up proof figures by departments with a grand total of all charges. The bookkeeper must balance her sheet against these figures.

Inasmuch as the services rendered our ward patients are largely chargeable to the City and County Welfare Departments, bills are not rendered separately for each patient, but are included in a monthly statement. For this service a flat daily rate is charged. Billing is done only when the patient is discharged or at the end of the month when all ward accounts are figured and brought up to date. For example, Arthur Chadock, a ward patient from the County Home, Beacon, N. Y., was admitted on June 11 and discharged June 22, 1932. As our charges (flat rate for ward service) were to be billed to the city of Beacon, the charge is entered on the white ledger card (Fig. 2) for ward patients and simultaneously is entered on the Income Register, Ward and Outside (Fig. 3) and distributed to Accounts Receivable Ward, Others, as the charge was neither against the Poughkeepsie Department of Public Welfare nor the Public Welfare Department of the County of Dutchess, both of which go in other columns. The monthly statements are made by copying the figures shown on the income register opposite the names of the various patients since these figures are the only charges for the month.

To VASSAR BROTHERS HOSPITAL, Dr.
POUGHKEEPSIE, N. Y.

NAME OF PATIENT DE VINE ADA MRS.
ADDRESS SALT POINT, N.Y. DATE 193
Bill To

MR. WILLIAM J. DE VINE,
SALT POINT, N.Y.

PLEASE RETURN THIS STUB WITH YOUR CHECK.

VASSAR BROTHERS HOSPITAL
ITEMIZED BILL FOR SERVICES RENDERED MRS. ADA DEVINE
Terms: Accounts are due weekly upon presentation of bill and in full on discharge.

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE
JUN 22 32	X-RAY	25.00		25.00
JUN 22 32	HOSPITAL SERVICE	38.50		63.50
JUN 22 32	NURSES BOARD	2.00		65.50
JUN 24 32	PAYMENT		65.50	0

To VASSAR BROTHERS HOSPITAL, Dr.
POUGHKEEPSIE, N. Y.

NAME OF PATIENT STOKES RICHARD MR.
ADDRESS DATE 193
Bill To

MR. RICHARD STOKES
17 ACADEMY ST.,
POUGHKEEPSIE, N.Y.

PLEASE RETURN THIS STUB WITH YOUR CHECK.

VASSAR BROTHERS HOSPITAL
SERVICES RENDERED TO MR. RICHARD STOKES

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE
JUN 22 32	X-RAY #45230	12.00		12.00

Fig. 4. At the top is a sample of the general billhead used for house patients, and at the bottom is a reproduction of the billhead used for outside patients having x-ray, laboratory and physiotherapy work done in the hospital.

The posting medium for charges for services rendered patients who are not in the house is the same as for the private and semiprivate house patients. These daily charge sheets (Fig. 1) have two columns in which the charges are recorded, one for private and semiprivate patients (Col. H) and the other for outside patients (Col. O). Patients' ledger cards and bills for these charges, when received, are headed up by the clerk at the information desk before the bookkeeper is ready to post. This clerk locates any previous cards and makes up all new ones in order to have everything in readiness for the bookkeeper to proceed with her posting.

The installation of a two-drawer cash register to use in connection with our posting machine has greatly improved our method of handling cash. Hitherto payments were entered in a cash book as they were made and often the clerk would be busy doing something else and the cash would be left on the desk or in a drawer until time could be found to enter it. As a result there were improper credit postings and an occasional loss of cash. The present cash register with its two drawers and control keys gives each clerk a separate drawer and makes it possible to hold her accountable for all cash taken in.

As a further precaution against arguments over payments, the machine is designed with a ticket chute for the bills with a space at the bottom for the machine to print a receipt. The date is also recorded through an automatic dating device. In using this machine the cashier first determines the kind of payment being made, that is, whether it is for an x-ray on an outside patient, the payment on a bill for a house patient, or the payment of an

emergency room charge. The cashier then locates the patient's ledger card, the bill is dropped into the ticket chute and the amount, with special character key indicating the kind of payment, is rung up on the machine. The bill is then returned to the customer and the patient's name is written on the detail slip in the machine. This detail slip is a double carbon roll. The machine is equipped with 1¾-inch spacing so that the top part of the roll can be torn off and used as a ticket for cash postings. This shows the patient's name, the amount paid and the department concerned.

The cash drawer is balanced each day at 3:45 p.m., and the tickets are sorted and posted. The tape giving the detail is removed and held by the bookkeeper to substantiate her cash journal. Inasmuch as cash bank deposits are made up on Tuesdays and Saturdays, the tickets are put with the cash in an envelope and held in the safe until the deposits are made up. The cash of each clerk is posted separately, the cash sheet in each instance showing either No. 1 or No. 2 cashier. The bookkeeper must prove her figures against the totals on the cash machine detail tape. Tickets are also listed by departments to prove proper distribution.

Bookkeeper Works on a Schedule

Inasmuch as all charges are distributed by departments and entered in the general ledger as income from these departments, it seems that the breaking down of the cash posting would be unnecessary. This, however, is not the case. Accounts receivable controls are carried for private and semiprivate, wards—city, wards—county, and like classifications, as shown on the top of the cash journal. All charges for services rendered private and semiprivate house patients are charged to accounts receivable, private and semiprivate, on the general ledger. When a payment is made on any such account the total amount is credited to private and semiprivate on the cash journal and if this payment includes payments for laboratory work, x-rays or physiotherapy treatments, this amount is posted in the memorandum account at the extreme right of the cash journal.

These memorandum accounts are kept because our pathologist, roentgenologist and physiotherapist are paid commissions based on cash receipts and not on the earnings of the departments. For example, on June 24, 1932, Mrs. Wm. J. DeVine, makes a payment of $65.50 which pays her bill up to date. She is given credit on the bill (Fig. 4). The credit is automatically recorded on her ledger card (Fig. 2) and then posted on the cash journal (Fig. 3) where it is distributed to accounts receivable, private and semiprivate; but inasmuch as this payment included a $25 payment for x-rays, $25 is posted in the x-ray memorandum account at the extreme right of the cash journal. The monthly totals of this x-ray memorandum account covering services rendered house patients, and the "x-ray (9)" column (Fig. 2), representing x-ray services rendered out-of-the-house patients, form the basis upon which the roentgenologist's monthly commissions are calculated.

A schedule of work for the bookkeeper has been established as follows:

8:30 to 10 a.m.	Pull ledger cards for departmental charges.
	Head up cards for new admissions.
	Pull daily discharges and figure hospital service charges and nurses' board.
	Figure current service charges on all inside patients.
10 to 11 a.m.	Post charges on inside patients.
11 to 12 a.m.	Post night cash; miscellaneous work.
12 to 1 p.m.	Lunch.
1 to 2:30 p.m.	Post outside charges and ward discharges.
2:30 to 3:45 p.m.	Miscellaneous work.
3:45 to 4 p.m.	Balance cash machine and sort tickets.
4 to 5 p.m.	Post current day's cash.

It is hoped later to introduce a unit charge ticket to replace the departmental charge sheet now being used. When this is worked out it will be possible for us to make several posting runs each day. This would give us the advantage of having all the current day's postings done on the day on which charges originate rather than on the following day; thus making sure that our ledgers will be up to date on patients discharged during the day.

Training of Diet Kitchen Personnel in Germany

As loose methods in the training of diet kitchen personnel have begun to be manifest, a number of diet kitchens where instruction is given at German clinics and hospitals have established a society, which already has thirteen collective members, according to the *Journal of the American Medical Association*.

These diet kitchens have adopted a uniform two-year course of study and training. The aim is to develop women directors of diet kitchens, who not only understand how to carry out a physician's prescriptions but can manage a diet kitchen from the standpoint of economics and organization.

Editorials

The A. H. A. Steps Out

"THERE seems to be a widespread feeling among our members," said Dr. S. S. Goldwater in his address at the Detroit convention of the American Hospital Association, "that although the association does some thinking and makes many gestures, it is weak and ineffectual in action."

If the feeling described by Doctor Goldwater existed, it should now be modified, for scarcely had the almost revolutionary report of the committee on plan and scope (Goldwater, Bachmeyer and Winford Smith) been presented when it was accepted in principle. Within forty-eight hours of the reading of the report resolutions were enacted creating a council on community relations and administrative practice which, subject to the trustees' approval, was empowered to seek such financial support as may be necessary to enable it to function effectively to form divisions in (a) the community relations of the hospital; (b) medical economics; (c) hospital medical practice and clinical statistics; (d) hospital accounting; (e) nursing, and such additional divisions or sections as may be found desirable.

The newly created council is authorized to formulate its own rules of procedure and within the limits of its budget to employ part-time or full-time investigators and secretaries. The council, which is to consist of fifteen carefully chosen members, will no doubt begin its work promptly and energetically, for in the changes in the organized practice of medicine which are impending—which are, in fact, already under way, witness the novel phases of hospital and clinical service, of group practice, of voluntary hospital and health insurance, of the expansion of government hospitals, of preventive medicine, of medical and nursing education—the influence of enlightened hospital administration is badly needed. With the machinery of the new council at its command, the A. H. A. will be in a position to make its influence felt.

We urge our readers to study the official report of the committee on plan and scope and the explanatory statement in regard to it which is embodied in Doctor Goldwater's address which appears on page 61 of this issue.

The A. H. A. has always been progressive, at times even militant, in its thinking. At a critical moment the association now steps boldly out into the controversial field of medical economics to study pressing problems and to safeguard the interests of hospitals and the public alike. We are assured that the attitude of the council toward organized medicine and organized nursing will be sympathetic rather than hostile. We look to the council, in the words of Doctor Goldwater, "to assign to the hospital its proper place in the social order," and to aid principally in establishing sound economic relations between hospitals, physicians, nurses and the general public.

We congratulate the trustees of the association on their courageous, unselfish and timely action in creating a new and useful agency, and in granting to it such ample powers.

"No Questions Asked"

ONE of the most intriguing problems confronting the social worker in the field of philanthropy, including hospitals, but one that is too often handled in a thoughtless way, is the depth to which the privacy of the client may be sounded for public scrutiny. It is in the front rank of social problems to be solved when the weak and dependent appeal to the strong for help in poverty, sickness, destitution or old age.

Someone, somewhere, having exhausted his own strength to survive, appeals for aid from his more fortunate fellow beings who, blessed with a reserve, have an excess to distribute in just such circumstances. But when a person calls for help, except when driven by an overwhelming emergency, as in the case of a fire when help is forthcoming as an instinctive response to the call for mutual aid, he must give reasons. From the giving of reasons it is a short step to the giving of evidence to prove the need and the donor or more frequently his agent the social worker, feels obligated to place in the record of the case every last detail that might justify the gift. The point is reached only too often of defeating the very object of philanthropy, for aid should be given by the strong to the weak, by "each according to his ability to each according to his need," as the right and privilege of a deserving recipient, because in this way alone, and not in penalizing him by exposing his intimate life to public view, are the health of the individual and the community protected. There are, as everybody knows, two important schools of thought with their own theories as to the relative value of public and private philanthropy from this point of view, but the problem meantime remains.

Thus we find the social worker's office becoming

converted into a sort of confessional for the sick, with the difference that no absolution is granted while a careful record is made of the facts, the accuracy of which is checked at considerable cost by home visits, so that others may see adequate justification for this bit of philanthropy. Much might be written on this subject, with which every hospital administrator is familiar from his own experience. Perhaps the fault is his and not that of the giver whose agent he happens to be.

One might indeed go a step further in the argument, and ask where is the administrator who has not personally observed with some regret the group method of treating patients in large open wards where the sick poor are herded and compelled to attend to their natural functions in the presence of their neighbors. Has any administrator ever forgotten his first experience of seeing a ward patient die in public? Yet, with the most poignant of examples before us, what are we doing to protect the privacy of those who come to us for help? Perhaps our natural instincts of mutual aid should be given freer play, without the inhibitory methods of their control elaborated, paradoxically enough, by an unreflecting society.

Under the circumstances, it is refreshing to read the signs over the doors of the district maternity clinics in Paris, where the municipality provides food twice a day to expectant mothers and to nursing mothers (no other identification being needed) as a contribution to the welfare of the community. "No Questions Asked." What if the undeserving do occasionally secure a meal at the expense of those who can provide it! The moral lesson is there for all the world to see.

The Union Wage Scale for Nurses

ONE question that is always before us—and probably always will be—is the nursing situation.

Educators, grading committees, forward looking nurses and many hospital superintendents agree that we are graduating too many nurses each year. Many remedies are suggested, but little if anything has as yet been done to reduce the number of student nurses that are used in our hospitals. One of the stumbling blocks comes in the form of economy to the hospital. It is claimed, particularly by the small hospital superintendent, that nursing schools are cheaper than the use of graduates and that any increase in hospital costs will be bitterly attacked by the lay public.

The latest solution offered is to prohibit or at least to discourage hospitals with an average daily occupancy of less than a hundred patients from having nursing schools. E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, advocates some sort of rating of schools of nursing similar to the hospital ratings given by the American College of Surgeons or the approval for internship listed by the American Medical Association. President Paul Fesler of the American Hospital Association states that all nurse education should be by state subsidy and under state universities. Dean E. P. Lyon of the medical school, University of Minnesota, advocates a complete shutdown of all schools until conditions clear. Other authorities offer other solutions.

Since we are prone to blame everything that has happened during the past thirteen years on the World War, the plight that nursing finds itself in is also blamed on the war. It has been stated that the shortage of nurses during and directly after the war brought on overenthusiasm and consequently overproduction of nurses, that a glamorous picture was painted to the high school girls showing the glories and, incidentally, the remuneration that were the reward of nursing and that now many of the nurses who were loudest in their championship of more schools of nursing feel that perhaps their voices were too convincing and carried too far.

One, and to our mind the best, solution of the entire matter comes in the suggestion for a sliding scale for private nurses' salaries. At the present time in every community a union wage is in force for graduate nurses. In Chicago it is seven dollars for twelve hours, whether these hours be night or day, and no nurse can hope for more. If she is the exceptionally good nurse she must still work for the same seven dollars that the exceptionally poor nurse commands. She does, however, get more work and can be a little more particular than her less able sister, but this is not to the benefit of the patients.

Since the average patient knows few nurses, he must take the doctor's word or must resort to the registry. The doctor in most cases asks the registry for a nurse. He does not specify the type of nursing to be done but usually takes the first nurse offered. She may be capable or she may not, yet she appears on the case solely by the right of theory that she has passed the state board, that she is a registered nurse and can handle any case she is called upon to handle.

If this union wage was removed and capable nurses allowed to charge as much as they could get and those of inferior quality be glad to get less than the existing pay, the rule of supply and demand would quickly go in force and only those who felt reasonably sure of making a good living would

enter the profession. Then, in addition, if schools of nursing were set up on a rigid standard and these students actually given a thorough training in nursing, it would be perfectly just to charge an adequate tuition exactly the same as for the training of any other profession. This would work hardships on hospitals that are incapable of giving an actual education but would probably work to the benefit of those institutions that give real training. Not only would the patients in the hospital and the community both benefit by this move, but graduate nurses would either prosper or leave the profession at once if it proved to be unprofitable.

Rewarding the Visiting Staff

THE position of the visiting staff member in the scheme of organization of the American hospital has been planned on the assumption that he will be paid for his services in the clinical experience that he enjoys from his favored appointment and in his charity to the poor. Every doctor knows that a good appointment in a good hospital is an investment, and that the man on the inside is the envy of his less fortunate colleagues who are on the outside. The practice of medicine, however, has become the target for the critics in recent years and some of its leaders have tried to divert some of the fire to the hospital which accepts their services. This has a definite relationship with the commercialization of medical practice which the worst as well as the best in the profession deplore.

Indeed, in many respects, the commercial factor is the controlling influence in the economic life of the physician, and may call down the judgment of the administration on his hospital activities. Next to the manifold ills which attend his lack or his excess of scientific enthusiasm come the evils which arise from his daily financial relationships with his patients. There is no profession on earth that will stand comparison with the practice of medicine from the point of view of humanitarian idealism. But where is the physician who does not regret the inconsistency of his position when he is obliged to sell his powers of relieving suffering for a monetary consideration as one would sell a commodity? The subjection of the medical scientist to the laws of commerce is one of the crying sins of our civilization. The fact remains, however, that the physician is by ill fortune the victim of a commercial environment and the need for earning a livelihood is bound to control the activities of the most ardent idealist so that his life becomes an eternal compromise with his ideals.

Whether it will be possible to continue to command the services of clinicians for routine medical work in the in-patient and out-patient departments without financial remuneration remains to be seen. There have been signs of unrest. The feeling in progressive hospitals seems to be that in a large measure the comfort of the patient depends upon the solution of this problem. The various methods of rewarding the medical man are being studied and greater encouragement to serve is now being offered. Medical men working in pathological laboratories, radiological laboratories (diagnostic and therapeutic), refraction clinics, the various clinics for physical therapy and arsenotherapy are mostly salaried workers. This group may eventually have to be expanded. Fellowships have come into vogue as a partial means of relief, but whichever method prevails in the end, the economic value of medical service must receive wider recognition.

In this connection, the report recently rendered by the joint committee of the British Hospitals Association and the British Medical Association, which held a series of conferences in London under the chairmanship of Lord Linlithgow to consider the question of the payment of visiting medical staffs of voluntary hospitals, has a number of conclusions and recommendations that are worth quoting:

"We are of the opinion that the time has come to recognize the claim of the visiting medical staffs to some share in the monies raised for the treatment of patients in hospital, other than those provided by voluntary subscription or donation for the treatment of free patients.

"We recommend the institution of contributory schemes wherever such schemes are not already in existence.

"We desire to record our opinion that the ideal contributory scheme is one in which the individual contributor shall contribute upon a basis designed to provide: (1) for the cost of maintenance of patients; (2) for a contribution towards the remuneration of the visiting medical staffs of the hospital or hospitals concerned.

"We recommend the provision in all suitable hospitals of a sufficient number of rooms or wards for paying patients, coupled with the strict application of a maximum means test for entry into general wards.

"We recommend that a standing joint committee of the British Hospitals Association and the British Medical Association should be constituted. This joint committee should meet from time to time in order to give advice to hospitals or medical boards seeking guidance, to keep each body in touch with the views and experience of the other, and generally to watch the situation."

Suggestions for the Program of Public Relations

AN EDITORIAL in the September issue of THE MODERN HOSPITAL emphasized the urgent necessity of our voluntary hospitals being safeguarded through a comprehensive educational program directed to the entire public.

It was pointed out that there is grave danger of this class of hospitals suffering out of all proportion to the severity of the adjustment in the business-economic situation because of the apathetic attitude of the public, the fact that for several years interest has been diverted from hospitals to emergency relief and that many former contributors are not now able to continue their support. Also, there has been developing for some years a critical and even antagonistic attitude toward hospitals in some quarters, this propaganda being furthered by cults and sensational journalists who choose to ignore both the principle that disease is a community responsibility and the fact that the hospital has been the chief agency of the community in meeting this obligation.

To quote from the September editorial:

"What of the solution of the problem? How can deficits be met? How can ample funds be made available for continued operation and for new facilities? How can we educate the public to provide a reserve for medical and hospital service when required? How are we to convince the substantial citizen of the hospital's worth to the community and to himself so that there will be the quality of appreciation that will find expression in voluntary support?

Nationwide Campaign Is Needed

"Only through an intelligent, coordinated and sustained program of public relations can this be done—a continuous sales campaign, describing it in the language of the public, that will interpret, educate and convince. Such a program should contemplate the enlightenment of the public through the press, from the platform and by means of visual education so that all citizens will come to recognize the vital function of the voluntary hospital in our scheme of modern social organization.

"A nationwide campaign is required and it must be maintained unceasingly in order to win back and hold the support of a public that is overbusy with its diversified interests and problems. The enlightenment must be sufficient so that the sensational statements of disgruntled patients and hack writers will be properly evaluated, since these will always be with us.

"Following periods of depression such as that from which we are now emerging, there come many new sources of potential philanthropy and these must be educated promptly to replace those which are no longer open to the hospital. Too frequently do we observe the worthy institution which has suffered because of its circle of active supporters being limited, perhaps to one family only. Statistics on the changing distribution of wealth in this country should warn us that the whole public, instead of merely the few, should know and be loyal to the hospital.

All Agencies Must Assist

"A comprehensive program of public relations to safeguard our voluntary hospitals is a serious undertaking. The plan should be laid out for at least a five-year period and there should be ample resources of personnel, funds and enthusiasm to ensure proper direction and continuity. To launch such an effort and carry it to a successful conclusion is too much of a task for any one organization or group now active in this field. Further, the larger success of such an endeavor calls for complete cooperation and harmony among all of the agencies and it must have the wholehearted support of every worthy hospital executive.

"To this task and serving primarily as an organizing agency the publishers and the editorial board of THE MODERN HOSPITAL will devote themselves and their facilities. It is proposed that the work be organized and directed by a committee with the chairman and executive secretary located at Chicago, thus ensuring closer contact with the national associations concerned with hospitals.

"Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, a man who has done much toward promoting better relations between hospital and public, has consented to act as chairman of this organizing committee."

As is the case with any other educational effort which aims to influence a substantial part of an entire population, a program of public rela-

tions must be continuous and have a sustained thread of interest in order to achieve its objective. It must be honest and in order to be successful it must have a high constructive purpose and it is essential that the various steps be closely integrated. It cannot succeed on a hit-or-miss basis.

What the Program Should Provide

In our approach to this problem emphasis has been placed on the protection of the private charitable institution, the so-called voluntary hospital, and rightfully so because its needs at the moment are the more urgent. It is obvious, however, that a better understanding of institutions for the sick on the part of the American people will benefit all hospitals that are worthy of the name. Also it is apparent that the tax supported institutions of many communities will need the assistance of a more tolerant and understanding public to safeguard them against the undiscriminating revolt of the people toward excessive taxation with the consequent unwarranted slashing of hospital budgets.

What should be attempted in this proposed five-year public relations program? It is the recommendation of THE MODERN HOSPITAL that whatever committee is to assume responsibility give due consideration to an educational campaign formulated to influence as nearly as possible all of the people of this country and Canada, this campaign to include (1) the printed word in its various applications, (2) the spoken word through a broad plan for public addresses and radio talks and (3) visual education through the news reels and the development of short 16 m/m motion and talking pictures.

In such a program the most far-reaching factor is the printed word. It is suggested that each year at least four nationally known authors who can write with authority, be induced to prepare appropriate articles for general magazines of large circulation. Also an essentially important part of the campaign would be a newspaper release service under strict supervision from headquarters. The editorial office of THE MODERN HOSPITAL has been giving thought to this subject for several years and twenty-eight releases have been written and approved by hospital authorities to whom they have been submitted. As a part of this service there should be data available through all state and local subcommittees for the immediate preparation of special news releases to offset unfavorable publicity that might arise in event of accidents such as the Cleveland Clinic disaster, the alleged "mixed baby" episode at a Chicago hospital, and other developments embarrassing to hospitals in general unless proper information regarding the protective measures common to all hospitals be made available to the newspapers when of timely interest.

Much desirable publicity of an effective nature can be had also through those who are responsible for the better type of syndicated newspaper editorials and special articles. Already several nationally known writers of this class have indicated a willingness to lend their aid.

Next in importance is the organization of a speakers' bureau which should be operated under the immediate direction of the central committee in cooperation with subcommittees in the several states. A place can be found on the programs of practically every national organization of manufacturers, educators, bankers, industrialists, veterans' associations and perhaps a total of one hundred other important national meetings each year for speakers of marked ability who have a message as clear-cut as can be developed around the subject under discussion. In a like manner this method of enlightenment can be used with local organizations, such as chambers of commerce, civic associations, women's clubs and various other groups. From these speakers there can be drawn some who are particularly qualified to talk over the radio. A set program of short radio talks, some on national hook-ups and others through local stations only, should be planned.

For part of the population there is no efficient substitute for the news reel, the motion picture and the talking picture. A series of short films of general interest could be made, probably without expense, that would give the public an interested understanding of many hospital procedures. These would be released through the regular channels and they also might carry their messages into schools, churches and to other audiences.

Must Build Good Will

Along with these educational efforts without the hospital, there should be developed more fully a spirit of cooperation and good will among patients, visitors, staff and other personnel within the institution. All must be made conscious of the value of hospitals to the community.

The cooperation of the editors of medical and nursing journals should be secured so that all members of these two professions will become more familiar with the problems of the hospital and more sympathetic toward the effort to safeguard and extend the appreciation of the public. Much can be done by staff members and special duty nurses to build good will and to offset criticism if they are properly informed and called on for cooperation. Articles in medical and nursing publications on various phases of hospital proce-

dures and problems, these to be written by prominent administrators, would help toward a better understanding.

The patient, his family and other visitors offer much in the way of opportunity for the building of loyal, interested support, but many hospitals must do more in the future to eliminate causes for complaint and dissatisfaction, also some must acquire a better technique in dealing with criticisms. A series of booklets and cards for the information of patients and visitors should be a part of the routine promotional work of the hospital so that interest in the community service of the institution will be stimulated and also so that the patient will at all times be informed regarding points such as rates, special charges and other items which might cause discussion or criticism. Most of the common complications between hospital and patient can be anticipated and prevented and nearly all patients can be made lasting friends. If hospitals in general gave as much thought to the building of good will among patients as hotels do to win the sustained support of their guests there would be little need for this paragraph.

Action Is Assured

There are many other features of a rounded program which it is unnecessary to mention here except perhaps to refer in passing to the broader function of the annual report of the hospital, special publicity in industry and organized labor, the long distance benefit from the introduction into school textbooks of information on hospitals (definite progress has already been made in this direction), the organization of hospital committees of chambers of commerce and equivalent civic organizations, the publication of a book on hospitals for the public, cooperation through church publications and a more complete utilization of the educational and publicity facilities of the federal and dominion governments.

Although the above was prepared merely as a series of suggestions for a comprehensive program and plan to be worked out in greater detail by a committee, when formed, it was received with enthusiasm by all with whom it was discussed at the recent meeting of the American Hospital Association. Everyone in hospital work seems to realize the need for a better understanding with the public and on the part of the public. Some students of hospital economics look for the solution of the present financial burden of voluntary hospitals to come through a form of insurance such as is now being put into effect by several hospitals. Others think the trend will be in the direction of state aid, as in Pennsylvania, or if not that, compensation for free work from the municipality or county. All are agreed, however, that educational work with the public, designed to create a better understanding and appreciation, is long overdue.

Many expressed the opinion that the educational program should be sponsored and carried out by the American Hospital Association with THE MODERN HOSPITAL and all other agencies cooperating to the utmost for the general good. With this opinion the editors and publishers are in hearty accord and to carry the matter to a conclusion, Doctor MacEachern of the organization committee, and Dr. Otho F. Ball, president, THE MODERN HOSPITAL Publishing Co., Inc., met with the trustees of the association on September 15 for a full discussion of the subject.

Action was taken by the trustees which gives assurance that such a program will be carried out by a committee on public relations of the American Hospital Association, the personnel of this committee to be representative of all groups and interests in the field. This announcement is made with the approval of the executive secretary of the association and it is presented here along with the suggested program as an open invitation for all hospital executives and others to send their comments and criticisms in care of THE MODERN HOSPITAL for the attention of the committee as soon as it is appointed. Further, it is requested that copies of pertinent addresses and radio talks which have been delivered or are contemplated, also other material likely to be helpful, be sent as promptly as possible for such value as they may have for the committee in planning its activities.

What Accidents Cost Hospitals and Physicians Yearly

That hospitals and the medical profession annually lose $25,000,000 in caring for the victims of automobile accidents, is the topic of an editorial in the *Illinois Medical Journal.*

"Either more drastic and penalizing legislation fixing the rehabilitation expense for the victim of the highway accident directly upon those who have caused the injuries, and in such a way that this liability shall be unquestioned, or some definite policy for reimbursement from other sources and without added burden to the taxpayer should be devised in some equitable and competent manner," says the editorial.

"The ideal method of handling this unfortunate situation that so unjustly increases the economic burden of accidents upon the shoulders of hospitals and doctors would be a form of insurance."

Doctor Faxon Named President-Elect of A. H. A.

Next Year's Meeting to Be Held at Milwaukee

THE report of the committee on plan and scope of the American Hospital Association, given by Dr. S. S. Goldwater, New York City, on Tuesday evening, the new scheme for a nationwide public relations activity and the general informal discussion and sentiment expressed on hospital insurance were the three high lights of probably the most beneficial program that has ever been presented at an American Hospital Association meeting.

The meeting was formally opened on Monday afternoon, September 12, and the attendance proved to be far above expectations. The people were not only there in large numbers but there was much intelligent discussion at all round tables, notably the round table conducted by Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, on Tuesday morning, which dealt with the support of hospitals in their present economic crises. At this round table expressions of opinion as to the possible solution of the financial ills of voluntary hospitals were given by many of the leaders in the field. Difficulties in dealing with insurance companies, the selling of hospital service to municipalities, the feasibility of the insurance plan, the obligation that the voluntary hospital has to do a certain amount of free work, state subsidy and other phases of the question were frankly argued.

Dr. Nathaniel W. Faxon, Rochester, N. Y., who was chosen president-elect.

As usual, many meetings were held at the same time, dietary, occupational therapy, record librarians, nurse sections and round tables appeared on almost every program.

At the Monday evening session held in the grand ballroom of the Book-Cadillac Hotel, an address of welcome was given by Dr. E. T. Olsen, president of the Michigan Hospital Association and superintendent of the Detroit Receiving Hospital. The high light of the program was the presidential address presented by President Paul H. Fesler, Wesley Memorial Hospital, Chicago. It appears as the leading article in this issue.

Mrs. Breckenridge Gives Stirring Address

On Tuesday evening a trustees' section was held at which Louis J. McKenney, trustee, Highland Park General Hospital, Highland Park, Mich., acted as chairman. It was at this time that Doctor Goldwater presented the report which also appears in this issue. This was followed by one of the most interesting talks that has been heard at any hospital association. It was presented by Mrs. Mary Breckenridge, R.N., Frontier Nursing Service of Kentucky. Mrs. Breckenridge stirred her audience with stories of the Kentucky mountains and the deplorable conditions that are met there by health workers.

Wednesday evening was set aside for the annual banquet, President Fesler presiding. The speaker of the evening was Dr. Royal S. Copeland, New York City. Particularly interesting, however, on the program were the readings given by Edgar

Guest, whose poetry appears in many newspapers of the United States. Following the banquet a reception and dance were held.

Thursday evening the general session on economic problems was presented, with Dr. W. L. Babcock, director, Grace Hospital, Detroit, presiding. At this time three important authorities were Dr. Hugh S. Cumming, surgeon general, U. S. Public Health Service, Dr. Dean De Witt Lewis, Johns Hopkins Hospital, Baltimore, president-elect of the American Medical Association, and Dr. Franklin H. Martin, director general, American College of Surgeons.

On Friday morning the closing session of the meeting was held with President Fesler presiding. It was at this time that the new president, Dr. George F. Stephens, Winnipeg General Hospital, Winnipeg, was inducted into office. Dr. Nathaniel W. Faxon, Strong Memorial Hospital, Rochester, N. Y., was unanimously elected president-elect of the association. Doctor Faxon for many years has acted as trustee of the association.

The following were elected as trustees: Paul Fesler, Dr. Winford H. Smith, Johns Hopkins Hospital, Baltimore and Carolyn E. Davis, Good Samaritan Hospital, Portland, Ore.

While there were not as many exhibits as usual this year, they were all well placed and the exhibitors were very much pleased with the response from those present.

Visits were paid to many of the Detroit hospitals, the Evangelical Deaconess Hospital, among others, attracting a large number of delegates.

It is to be regretted that all of the abstracts given at the meeting cannot be presented in this report, and it is to be further regretted that much of the round table discussion must await its appearance in the transactions. However, THE MODERN HOSPITAL has been able to abstract and present here many of the leading talks.

At the annual meeting of the Hospital Exhibitors Association held during the convention the following officers were elected for the coming year: president, Wallace M. Morton, Simmons Company, New York City; vice president, F. J. Wilson, Wilson Rubber Company, Canton, Ohio; secretary and treasurer, Logan M. Eldridge, Ad Siedel & Sons, Chicago.

Significant Statements by Convention Speakers

Extraordinary Sources of Revenue for Hospitals

George D. Sheats, Baptist Memorial Hospital, Memphis, Tenn.

If the pay patient revenue is insufficient to meet current expenses, much less to create necessary endowments, hospitals must seek other means to carry on, Mr. Sheats pointed out. The operation by the hospital of an office building for staff physicians is one of the best ways of raising the needed revenue. His convictions are based upon the successful operation of such a building at his own institution for the past five years.

He described in detail the advantages accruing to the physician, the patient and the hospital in such an arrangement. Thirty of the fifty-four physicians who are tenants of his hospital's office building have expressed themselves as highly pleased with the arrangement. All of them agree they are practicing under better conditions and are accomplishing far better end results under the new arrangement than ever before.

Such a building will provide revenue from many sources. There is the additional out-patient work, and, if a hotel is operated in connection with the building, the revenue from guests.

During the five years of its operation the office building has brought in the following revenue: office rentals, $300,000, or $60,000 per year and hotel accommodations, $60,000, or $12,000 per year. Additional revenue was derived from the drug store and the out-patient work.

Only physicians and dentists who are staff members should be considered as tenants. All revenue should be used for the care of the community's indigent sick, and upon retirement of the bonds the income should be absorbed by the hospital in reduced rates.

Politics, Politicians and Hospitals

Dr. Joseph C. Doane, Jewish Hospital, Philadelphia

There is not a municipal, county, state or federal hospital in which the efficiency of the institutions is not lessened to some degree because of political influence. Doctor Doane described the part that the tax supported hospital is expected to play in the political plan of the average community, and cited numerous examples of how political influence has interfered with the proper operation of these institutions.

He believes that a joint committee representing the American Medical Association, the American Hospital Association and the American College of Surgeons should be formed to outline approved administration methods for government hospitals.

He feels that a nonpartisan board of trustees, composed of leading citizens, would add permanency and stability to the administration of county, state and city hospitals. This board would stop the entrance of petty politics into the hospital.

Doctor Doane is of the opinion that the American Hospital Association, in order to justify its existence as a leader, must take action to eliminate political influence in the conduct of hospital affairs.

Grading Findings Related to Quality Nursing

Dr. May Ayres Burgess, New York City

No one thing can wreck a hospital's reputation more completely than poor nursing or build it up more swiftly than good nursing.

Poor nursing can defeat the physician's work in arriving at a diagnosis and in conducting treatment. The nursing care that patients receive largely determines whether or not patients will help support that hospital after they have recovered from their illness.

"As nursing is organized today," Doctor Burgess stated, "the quality of nursing service given on the ward is the most important element in the entire educational process. Most of the student's time is spent on practice. The practice of good nursing makes a perfectly good nurse, but the practice of poor nursing makes a perfectly awful nurse. Even with our enormous overproduction of nurses in this country, there is a shortage of good nurses. The reason is that there are many schools which, because of the shortage of competent graduate nurses on the ward, are allowing their student nurses to spend three years in practicing poor nursing methods."

Paul H. Fesler, Wesley Memorial Hospital, Chicago, the retiring president.

One way of providing better quality nursing on the wards, Doctor Burgess suggests, is for hospitals to abolish the monthly allowances paid student nurses—still the practice in 88 per cent of the hospitals—and to use this money for increasing the graduate nursing staff. Adding more registered nurses to the staff and putting them on a six-day, forty-eight-hour week, she maintains, will so lighten their load that they will have more time and energy to think about the needs of the patients and to watch the work of the students.

The Present Nursing Problems

Mary M. Roberts, American Journal of Nursing, New York City

The small general hospital in the large city has no financial right to conduct a school of nursing. Better equipped institutions can amply supply the community with graduate nurses.

In expounding this view, Miss Roberts made the following suggestion: That the A. H. A. and the national nursing organizations together work out the principles involved in deciding the small hospital superintendents' question, "Shall we close our school?"

Defining a small hospital as one of less than 100 beds, Miss Roberts developed the following points:

1. Small hospitals in urban centers where large hospitals can carry schools with less cost per student should close their schools.

2. If small general hospitals in less well hospitalized areas accept the responsibility for conducting schools, they should do it as a community service and expect to secure community aid in supporting it.

3. Competent graduate nurses can be interested in both administrative and staff positions in small hospitals provided they can be given reasonable hours, adequate incomes, and opportunity for growth.

4. The closing of a school and the setting up of a graduate service should be done with precision and should be based on accepted principles of personnel administration. To protect the public from quackery, safeguards must be set up preventing subsidiary workers from going out from the institution and representing themselves as nurses.

Hospitals and the Public Health

Surgeon General H. S. Cumming, U. S. Public Health Service, Washington, D. C.

The hospital is the most efficient means to care for the sick and the quickest way to restore a patient to normal life.

In clinical research the hospital has an almost exclusive field. The physician, surgeon, dentist, pathologist, bacteriologist, pharmacist, chemist, physicist and technician meet on common ground in the hospital, where they pool their best efforts.

We are faced with grave problems involving treatment and control of many diseases. Medical research on these problems is being carried on in the hospital.

As the eradication of leprosy depended vitally upon the hospital, so is the eradication of tuberculosis dependent upon hospitals. In the United States alone there are now more than 600 institutions where tuberculous patients are treated.

We have learned that mental disorders and a host of nervous diseases are preventable in a measure. Just as the sanatorium and hospital were the first requirement in the tuberculosis campaign, so they will be in treating mental disorders. The large general hospitals will need facilities for the observation, diagnosis and classification of mental patients.

It is difficult to check the sources and control carriers of venereal infections except in an institution.

The Place of the Public Hospital in the Community

William L. Coffey, Milwaukee County Institutions, Wauwatosa, Wis.

The public hospital, well managed and well directed and maintaining acceptable standards, should be the center of preventive and curative medicine in the community.

The city hospital and the county hospital are fast moving into a position of prominence in the hospital field. In the years to come the field of service of the community hospital will widen.

The city or the county hospital can make but a small contribution to the community health program unless it commands and has the confidence of the public. This type of hospital has taken over a big sector in the campaign of preventive and curative medicine. A shortening of the lines can not be expected in the near future. Therefore, it behooves the community hospital to put its house in order. The business office must close the ever popular avenue of attack on public institutions by stopping every possible waste.

Dr. George F. Stephens, Winnipeg General Hospital, who takes office as president of the association.

The public hospital should compare with any private hospital in the community. It should be staffed by the best physicians and surgeons of the city. This hospital should have highly trained personnel; it should be a teaching institution and a training center for nurses and for all types of technicians.

The city hospital should not knowingly admit a patient who can afford to pay a reasonable rate in a private hospital, neither should the city hospital accept a patient who can afford to pay for the service of a private physician in the community.

Relation of Source of Capital Investment to Cost of Hospitalization

Dr. William Henry Walsh, Chicago

The effect of the method of acquiring capital funds upon the cost of hospitalization was the theme of Doctor Walsh's discussion. Among the propositions touching upon fundamental considerations of this problem that he mentioned in his talk are the following:

1. There are three different types of nongovernment hospitals from the standpoint of the source of capital investment: (a) the nonprofit endowed hospital; (b) the nonprofit hospital with borrowed capital, and (c) the commercial hospital established for the object of profitable investment. The

Dr. Bert W. Caldwell, executive secretary of the association.

justification for the continued existence of type (b) without organized public approval is questioned.

2. The normal cost of adequate medical and hospital care is so high and the average income so low that under the present social and economic system the average citizen cannot afford to meet the cost of interest on capital investment, if indeed he is able to meet reasonable operating charges.

3. In view of the foregoing proposition there is no justification for any group, pretending to be eleemosynary in character, deliberately to saddle the burden of capital investment charges on to the prospective patient without his knowledge and consent. Such obligations are rightfully the direct responsibility of the governing body incurring the loan.

4. The charge to a pay patient in an eleemosynary institution should be based entirely on the operating costs, including depreciation charges.

5. Unless the independent hospitals can furnish hospitalization and medical care combined to people of moderate means at a cost within their ability to pay, the inevitable result will be the preemption of this field by the tax supported institution. Under proper safeguards such institutions may well be looked upon with favor.

6. In addition to the crying need for a certificate of public convenience and necessity prior to the inauguration of a hospital project, there should be some means whereby new hospitals might be forced to plan, build and equip in a manner suitable to the specific needs and in accordance with those standards that have gained almost universal acceptance.

Hospital Collections and Pledges

Frank Van Dyk, Hospital Council of Essex County, Newark, N. J.

Successful experience in collection of hospital accounts indicates that a proper procedure upon admission and discharge must be carried out if any collection plan is to achieve maximum results.

While proper admission and discharge procedures do not prevent an account from becoming delinquent, they do in a large measure reduce their frequency. When the account becomes delinquent they contribute important factors which tend to increase the possibility of collection. Therefore, no collection method can be successful without these important factors. Moreover, it must be remembered that no matter how well one carries out a sound admission procedure, its benefits are greatly reduced and frequently lost by laxity in the manner in which a patient is discharged.

Likewise, if both admission and discharge procedures are good, the benefits therefrom in collection of deferred payments will be minimized or entirely lost by inadequate follow-up methods.

Mr. Van Dyk outlined in detail the proper procedures to follow in admission and discharge and in following up delinquent accounts.

He feels that a hospital should demand prompt payment of bills the same as is done by any regular business institution.

Social Service and Rehabilitation of Tuberculous Patients

Dr. Max Biesenthal, Winfield Sanatorium, Winfield, Ill.

The purpose of treatment in pulmonary tuberculosis as in any other pathological condition is to prolong life, to relieve symptoms, and to restore the individual to his social and industrial existence.

The purely medical and surgical procedures, in themselves, have not and probably will never be sufficient to produce such results as will be of value in preserving life or restoring the patient to an economic stability.

It is in recognition of this fact that modern organizations have instituted, in addition to the orthodox method of treatment, social service supervision. The trained social worker, alert for the social ills which cause and accompany sickness,

makes contact with the patient and his family at the time of diagnosis or as soon after as possible. She follows him into the institution, through the institution, and, for a period of at least five years, after his discharge. At the same time she keeps in contact with his family and ministers to their needs.

As a part of the treatment of the disease and as a part of the social rehabilitation, institutions should attempt to give the patient, in addition to the usual rest, a graduated system of exercise. Workshops are of infinite value in carrying out this plan. Patients should not be discharged from an institution until they are able to do eight hours' exercise for a period of at least six weeks.

Before leaving the institution, the patient should be referred to a placement worker who is conversant with his home environment, his physical condition and his mental makeup, and who through contact with various employers, attempts to place him in a suitable position. This placement work, which restores the individual to industry, is an important step in the treatment of pulmonary tuberculosis.

Contact with the patient and his family for a period of at least five years after discharge, and repeated physical examinations will usually keep a patient from suffering a relapse.

Possible Educational Activities in Nonteaching Public Hospitals

Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y.

Teaching activities in the average hospital were reviewed by Doctor Munger who stressed the value of this kind of work. He told how it benefits the staff member, the intern, the nurse and all others associated with the hospital. It is generally acknowledged, he said, that the efficiency of a hospital is greatly increased when a "teaching atmosphere" prevails throughout the institution.

He pointed out, however, that of the thousands of hospitals in this country, only a few can be attached to medical colleges and actually be teaching hospitals according to the general meaning of the term. Doctor Munger believes, though, that every hospital should introduce as much teaching influence as is consistent with its facilities. He said it is the duty of the public hospital to engage in teaching activities since this is one of the most effective means for promoting efficiency in operation.

Doctor Munger feels there are many teaching possibilities in the so-called nonteaching hospital. One of these is nurse education, which he believes tends to elevate the nursing work of the entire hospital.

Another teaching possibility is organization of a course in dietetics. He told how one large hospital which would normally require nine graduate dietitians is able to handle its dietary work with five graduate dietitians and six student dietitians as a result of having established a course in dietetics.

The x-ray department can take on a limited number of students for proper preliminary education, in order to teach x-ray technique.

Public hospitals that maintain modern laboratories are better places for students to learn laboratory technique than many of the schools maintained for the purpose.

Proper educational facilities for the medical personnel is of utmost importance in every hospital. Doctor Munger believes that the educational program for interns used at Montefiore Hospital for Chronic Diseases, New York City, is suitable for adoption by nonteaching public hospitals. He described how each new class of interns arriving at this hospital is made acquainted with the various functions of the institution by being brought into close contact with the pharmacist, the chief social worker, the chief nurse, the dietitian, the pathologist and the head of the x-ray department.

Doctor Munger is of the opinion that the monthly staff meeting does not provide sufficient educational opportunity for the staff member of a modern hos-

Dr. C. W. Munger, who was prominent on the program.

pital. He feels there should be divisional meetings, ward rounds, grand rounds, pathological conferences, extra reading of medical literature and studies made of a research nature. He also is of the opinion that the public hospital should extend its educational facilities to all members of the medical profession practicing in the hospital's territory instead of confining these advantages to its own staff members.

Extending Private Hospital Facilities to Chronic Patients

Dr. Herman Smith, Michael Reese Hospital, Chicago

In an attempt to produce added revenue, the first floor of Meyer House, the private patients' building at Michael Reese Hospital, was this spring made available to chronic patients.

This floor is rather ideally laid out for the purpose. It has yard level porches opening from practically every room, a fairly spacious garden court and wheel chair facilities. Because of the rather complete physical therapeutic facilities of the hospital, it was thought that a number of patients suffering with chronic arthritis might utilize the service. The regular weekly rate was reduced 25 per cent and a monthly rate was established approximately 30 per cent less than the regular rate.

Dr. S. S. Goldwater, who reported for the association's committee on plan and scope.

These facilities were advertised to the medical profession of Illinois, particularly in Chicago, and the lay community supporting the hospital.

But in spite of good facilities, reduced rates, and rather wide advertising, not a single response has been received from either the medical profession or the laity since the unit was organized three months ago.

Mr. Bacon, Mr. Fesler and Mr. Wordell were good enough to inform me of the number of patients who had occupied private rooms or private wards for more than three months in Presbyterian, Wesley and St. Luke's hospitals, Chicago, on August 10, 1932. These figures added to those of Michael Reese Hospital show the following:

Six patients had been in private accommodations in these hospitals more than three months and less than six months, and five patients in similar accommodations more than six months, or a total of eleven private chronic patients. The combined census of the four hospitals on this day was approximately 1,100 patients. Therefore, approximately one-tenth of 1 per cent of the patients in these hospitals were private chronic patients.

Investigation of a private sanatorium in Chicago, where ordinarily a large number of chronic patients are treated, revealed the fact that there had been a decrease of from 35 to 40 per cent in the number of patients treated in 1932 as compared to 1931. The rates in this sanatorium are only $35 per week, and the cost covers physiotherapy treatments and physicians' fees.

It is my belief that at this time general hospitals should not expend any funds upon the development of a program to attract private chronic patients.

A Medical Approach to Hospital Administrative Methods

Dr. F. G. Carter, Ancker Hospital, St. Paul, Minn.

Doctor Carter showed how the medical profession has, after centuries of experience, analyzed its problems and set up a structure which not only initiates the novice into the profession, but also serves as a lifelong guide to those who practice its precepts.

He feels that while knowledge of hospital administration is abundant, still it is not sufficiently crystallized to assist beginners to work effectively; neither is it able to furnish those already in the field with the perspective that is so essential to efficient administration.

In expounding this view, he presented a description of the structure of medical science so as to show how hospital administration might be standardized and unified along analogous but not necessarily similar lines.

Report of Committee on Simplification and Standardization

Chairman, John M. Smith, Hahnemann Hospital, Philadelphia

The report showed that standards had been approved during the past year for surgical dressings, surgeons' gloves, rubber sheeting, steel bone plates and screws, and labeling of percentage of wool in blankets.

Efforts are now under way to complete standards on the following items: mattresses for beds and cribs; pillows; chrome, stainless or rustless steel for surgical instruments; labeling of quality of wool in blankets, and spring construction for children's cribs and bassinets.

One of the principal activities of the committee during the year was having clinical thermometers tested to determine their reliability. The tests were conducted by the Bureau of Standards.

The committee gave some consideration to the matter of securing a laboratory connection for routine testing of laboratory supplies and for research of hospital procedures, but no definite action was taken in this matter.

Hospital Participation in Child Welfare

Dr. Clifford G. Grulee, Rush Medical College, Chicago

The White House Conference on Child Health and Protection brought out many facts relative to the hospitals of this country. The conference revealed that the majority of our hospitals have not yet begun to realize their functions in child care.

A survey in 1930 showed that there were 6,667 hospitals in the United States with a bed capacity of 905,246. Of these beds 81,055 were designated for children, and in addition there were 47,939 bassinets. This means one bassinet for each nineteen hospital beds and one children's bed for each thirteen children, or approximately 13 per cent of the hospital beds assigned to children. While children under fourteen years of age constitute about 20 per cent of the population, for various reasons this 13 per cent at the present time seems an adequate number of beds for children.

It was gratifying to the Committee on Hospitals and Dispensaries to discover that there seems to be a general recognition among hospitals of the fact that care of children must frequently be carried on as a charitable procedure.

It is very evident that not enough hospital beds are available for Negro and Indian children.

Only 56 per cent of the hospitals surveyed have a pediatric staff. This is not a question of economy because it would cost a hospital nothing to designate a trained member of its staff as pediatrician.

Most hospitals have not realized their duty with respect to instruction of nurses and nutrition workers in the care of children. Only about one-fourth of the graduate nurses are properly trained in child work. It is the duty of hospitals in most communities to assume leadership in educating the people in child health matters. The development of infant welfare clinics in connection with hospitals is of the greatest importance.

Planning Hospitals for Children

Albert Kahn, Architect, Detroit

In his treatise on the planning of children's hospitals, Mr. Kahn considered the individual structure devoted specifically to the care of children rather than the pediatric division of a general hospital.

The prime objects of a children's hospital were named as follows: (1) the care and cure of sick children; (2) the education of physicians, both undergraduate and graduate; (3) the education of nurses in the care of children, and (4) the teaching of parents to assist in the prevention of disease.

Because the children's hospital serves mainly the poor, it is essential that it be located somewhere in the city, easy of access. The number of beds to be occupied, the ground area, the topog-

John M. Smith, chairman of the committee on standardization and simplification.

Dr. Joseph C. Doane, who spoke on the influence of politics in public hospitals.

raphy and the funds available will dictate the type of plan and also the number of floors required.

Keeping all activities under one roof rather than in several buildings has proved economical. The heating plant and laundry are perhaps best separately placed. Possibility of expansion is an important point to keep in mind. Many authorities believe that 250 beds should be the maximum for any hospital.

Children like company and therefore small wards are preferable. The wards should contain about four beds. The open nurses' station is generally preferred. At least one isolation room should adjoin each group of wards.

Food Cost Control

W. M. Meyer, Chicago

Food control has convinced many hospitals that there is considerable waste in their food departments, caused by a great many factors.

Briefly, a practical and efficient food control system means: (1) control of purchasing; (2) standardization of portions; (3) control of preparation, and (4) reduced food cost per meal without a lowered standard of service.

The speaker offered the following suggestions for reducing food costs: Concentrate buying power and abolish standing orders; carry small cans of fruits and vegetables for special orders so as to eliminate waste and spoilage; study market conditions so as to learn at what seasons of the year it is cheaper to serve fresh vegetables, and keep in mind that quality is cheaper in the long run.

In connection with standardization of portions, he said it is necessary to know: (1) the number of slices of bread in each loaf; (2) the number of slices of ham per pound; (3) the number of portions per pound of cheese; (4) the number of ice cream servings per gallon; (5) the number of portions per pie; (6) the number of ounces of beef, fish or poultry per serving for various diets; (7) the number of ounces of milk and cream per serving, and (8) the number of pieces of butter per pound.

Report of Committee on Hospital Organization and Management

Chairman, G. Waite Curtis, San Francisco

Business records and business methods in hospitals have noticeably improved during the past several years. Business methods act as an administrative guide within the institution itself and as a medium of comparison of the business operations of one institution with another. In order to make comparisons it is first necessary to have uniformly compiled data. Uniformity does not necessarily mean to be identical, but the accounting methods and business procedures must be complete.

The committee believes that the American Hospital Association should undertake a program to introduce better business methods in hospitals. It suggests that the association establish a separately financed bureau to handle this work. The results would be available to all hospitals.

Such a program would involve a study of the needs of all types of hospitals. This study should be made by persons expert in their knowledge as well as expert in sound business procedure.

It would involve detailed recommendations for all classes of hospitals, tax supported, nonprofit and proprietary. These recommendations would include uniform accounting classifications, business forms and detailed instructions on procedures to be followed. It would include improved methods of classification of current expense items and current revenues. It would include recommendations for the handling of fixed charges on capital investment. It would include instructions regarding purchasing, employment and collections.

This work for the three classes of institutions enumerated should be so correlated that comparative results and statistics of operation would be possible.

Responsibility of the Children's Hospital to Its Interns

Dr. Thomas B. Cooley, Detroit

One of the most important responsibilities of a children's hospital is to provide for the young physicians of its house staff the most adequate facilities in its power for training in the special practice of pediatrics.

Regular supervision in the out-patient department is essential to good intern training. Interns should be made more familiar with the problem of child guidance and mental hygiene. Intern teaching from ward cases should be more systematic than is often the case at present. Clinical and pathological conferences, well organized and well attended by the visiting staff, should be more general.

Children's hospitals not having the services of salaried teachers of medical schools can hardly attempt much longer to meet their teaching responsibilities without some provision for a salaried director.

The ambitious intern will desire at least three hospital years, with part of this time spent in the laboratories. It would be desirable if men taking the longer course were able to divide their time between hospitals in different parts of the country. A definite plan is needed to bring about some such arrangement.

Hospital Organization—A Group Staff Plan in a Rural Center

James A. Hamilton, Mary Hitchcock Memorial Hospital, Hanover, N. H.

Five years ago the medical staff of Mary Hitchcock Memorial Hospital was organized as a group clinic. This was done in the belief that improved service would be provided at lower cost.

The group is a partnership of all the members of the hospital's staff, with common facilities, personnel, equipment, income and expense, and combined medical practice for the entire community, both pay and free patients. The clinic rents office and clinical space in the hospital buildings and uses some personnel in common with the hospital organization, but otherwise operates as a separate unit.

From the standpoint of the members of the staff, this type of organization permits an increase in the available equipment and special apparatus. Each staff member is allowed a yearly vacation without loss of income, and every year he is sent on a two-week clinical trip. The business aspects are generally left in the hands of office assistants, thus relieving physicians of this work.

The rather common objection to organized medicine, namely its competition with the individual practitioner, is avoided because all the practitioners in the town of Hanover are members of the staff. They do not go outside of the township in the practice of medicine.

Richard P. Borden, one of the best known of the association's trustees.

Among the benefits of such staff organization in the administration of the hospital are: combined purchasing of supplies often results in lower prices; better equipment is possible, and the centralization of records, equipment and available funds makes it easier to carry on a program of educational research.

Value of a Receiving Service in a Tuberculosis Sanitarium

Dr. P. S. Winner and Dr. Frank Fremmel, Municipal Tuberculosis Sanitarium, Chicago

Prior to 1929, new patients entering the Municipal Tuberculosis Sanitarium were placed according to existing bed vacancies. There were many weaknesses in this method.

A receiving service was established in 1929 and since that time the average duration of residency has shown a downward trend. The receiving service is under the supervision of one senior physician and two junior physicians.

A card index system was installed in order that the receiving service might have a complete record of each case at the time of admission. This is an aid to the physician as well as to the sanitarium. A cross index file similar to that used by the Massa-

chusetts General Hospital, Boston, was adopted. This gives a permanent record of the patient's condition at the time of his discharge.

In order to provide a complete record of changes in the patient's condition during residence, ward physicians are required to fill out a card for the receiving service that shows any change in the classification of the patient, any complications that have arisen since the previous examination and any associated diseases with which the patient may be afflicted. The consulting staff gives the receiving

Dr. F. G. Carter, who spoke on hospital administrative methods.

ward a complete report on all cases. In this manner, all essential facts are centralized in one unit.

A visualization record system has been devised which indicates by room and ward number all available beds in each division.

The value of a receiving service in relation to the activities of a sanitarium may be summarized as follows: (1) Proper reception of all new cases. (2) Uniform instructions to the patients can be carried out to better advantage. (3) Prompt and systematized attention can be given the patients. In this way both the patient and his relatives are better satisfied. (4) It leads to early and accurate diagnosis. (5) Clinical and research investigations can be more satisfactorily conducted. (6) Overlapping and confusion of orders are eliminated. (7) Unnecessary overburdening of the consulting staff is avoided. (8) Methods of precision in diagnosis are more accurately carried out. (9) The length of residence is shortened. (10) An adequate cross index file can be maintained and statistical data can be more satisfactorily correlated. (11) Therapeutic measures can be promptly instituted and better directed. (12) A record board can be maintained which visualizes the medical activities of the sanitarium. (13) Conferences are systematized for the purpose of treatment, diagnosis and discharge. (14) Administrative centralization is facilitated.

Extending Existing Facilities in Private Hospitals to Contagious Cases

Dr. F. Adams, Windsor, Ont.

The operation of properly constructed isolation wards on the grounds of a modern general hospital has many advantages, according to Doctor Adams. He does not believe there are any disadvantages in such an arrangement.

Among the advantages that he mentions are: (1) The patient is assured of a high quality of nursing and medical service; (2) the municipality is assured of proper care of infectious diseases at reasonable cost; (3) nurses and interns are given valuable training in the care of infectious diseases; (4) the hospital will be helped economically, and (5) the hospital is relieved of worry in caring for infectious cases that may develop among patients or members of the institution's personnel.

The isolation hospital may be supplied with heat, hot water, steam and electricity from the power plant of the main hospital, Doctor Adams stated, in outlining a plan for the establishment of facilities for the care of infectious diseases in conjunction with a general hospital. The main hospital can supply food in bulk and provide laboratory and dispensary service. The x-ray and surgical equipment in the main building and the main laundry can be used by the isolation department provided certain simple precautions are observed.

The isolation building should be of special construction, the simplest type being a single corridor building. The wards usually run to a high proportion of single bedrooms. Each ward should have its own washbasin, hooks for hanging up gowns and provisions for holding paper bags for the disposal of waste. The rooms should be furnished in a simple manner. The kitchen should contain facilities for sterilizing dishes, and the sick rooms should also be equipped with sterilizing facilities.

The head nurse should be specially trained in caring for infectious disease patients. A specially trained doctor is also an asset, Doctor Adams said.

Aims and Purposes of Ladies' Auxiliaries

Margaret Rhynas, Women's Hospital Aids Association, Burlington, Ont.

"We do not want to run hospitals. We want to make it easier for hospital boards and superintendents to do so," said Mrs. Rhynas in explaining the aim of the organization which she heads as president. She stated that this is her association's creed.

She told of the work that the various aids are doing and asked that they be encouraged to the end that they will be sufficiently enthusiastic to continue their activities. In citing several specific cases of assistance given by members of her organization, Mrs. Rhynas told of one aid who has given approximately $300,000 to a certain hospital and its nurses' home, of another aid who has $12,000 ready to give for the furnishing of a new wing to a hospital when it is completed, of another aid who furnished the children's wing, diet kitchen and sunroom in a hospital and of another who paid for the construction of a nurses' home.

Report of the Committee on Public Relations

Chairman, Dr. M. T. MacEachern, American College of Surgeons, Chicago

The report concerns itself primarily with two basic considerations—first, how the hospital can best serve the community; second, how the hospital can make itself known to its community.

The committee believes that the hospital can best serve its community by extending its services and assuming its rightful place in the life of the community. It favors the organization of a health council in which the hospital would be a prime factor. The membership of the council would be representative of all the hospitals in the community, the local health department, the medical profession, the nursing profession, the visiting nurses' association, social service agencies, welfare organizations and other recognized groups serving in the welfare of the community.

The committee also urges the formation of health education forums and of health inventoriums as two ways of improving health conditions. The public should be invited to attend these forums, when brief nontechnical talks should be given accompanied by visual demonstrations, motion pictures and other features.

The organization of a health inventorium offers a valuable means for the hospital to enlarge its services to the community and make itself better known. Many hospitals provide facilities for physicians for use in making periodic health examinations of their patients.

The spoken word, the written word, visual means, may all be used in countless ways as effective means of educating the public with regard to the hospital. The report enlarges on all of these in detail.

The second part of the report presents a one-year program of public education regarding hospitals. The following suggestions are offered:

1. The Patient's Book. This should be a booklet of general and specific information to be presented to each patient on admission. It should include information concerning visitors and other regulations, and should extend a welcome to the patient and leave a pleasant impression.

Carolyn E. Davis, Portland, Ore., who was elected a trustee of the association.

2. Articles for the press should be released monthly or oftener.

3. Talks or addresses should be given before schools, community service clubs and business organizations, at least one important organization being covered each month. Clubs and other organizations may be invited to hold their luncheon meetings at the hospital, when brief talks about the institution should be given and an organized tour of inspection made.

4. A well planned program should be arranged for National Hospital Day.

5. One Sunday should be set aside as Hospital Sunday, not as a collection day but as an appropriate occasion for inspirational talks by a local

or selected speaker and the morning or evening service should be given over to the address.

6. Informal letters may be sent to relatives and friends of patients, impressing upon them that the patient is receiving the best care, telling them about the visiting hours and inviting them to go through the hosptal. This makes friends for the hospital.

7. Follow-up letters should be sent at stated intervals to discharged patients inquiring about their health and keeping them informed as to hospital progress.

8. Arrangements should be made with one of the community broadcasting stations for a weekly fifteen-minute period to be devoted to a talk on health and hospitals.

9. A mass community health meeting should be arranged for each year. This should include a series of short addresses, illustrated with colored lantern slides and motion pictures.

10. An interesting and informative annual report should be distributed to past, present and prospective benefactors and to all influential citizens.

Value and Administration of the Hospital Library

Elizabeth W. Reed, Massachusetts General Hospital, Boston

The speaker first briefly explained the value of a library under trained direction, and then, in some detail, the administration and costs of various types of library service, one of which, she said, should be easily available to every hospital in the country.

She told how books help patients to forget their illness, and, in addition, described a case where the facilities offered by her own library not only assisted a woman patient in recovering the use of her muscles but changed her from a depressed and irritable patient to a confident convalescent. A good library is also valuable to the hospital from a publicity standpoint.

Many hospitals have no books and no library service. At the other extreme are a very few hospitals which have well equipped libraries—and between these are many variations. Of these, only two systems have been found successful, the unit system and the group system.

In the unit system the library is owned and operated by the hospital, while the group system consists of a joint arrangement with the local public library system. The group arrangement is best for the small hospital that can not afford a full-time librarian.

The unit system is the ideal arrangement for the large hospital that is financially able to maintain a definite department and a full-time trained librarian as a member of its staff.

Hospitals have found that the cost of a library department is the lowest of any department in the hospital and that the service rendered reaches further. In planning for a library it is well to allow from $0.75 to $1 per bed capacity, or two books to a patient, as a guide for a nucleus.

Hospital Cost Analysis

Alexander Ropchan, A.M., University of Chicago

The paper suggests a simple yet reasonably accurate method of estimating, quarterly or semiannually, the costs of the various hospital revenue producing departments, which will provide the superintendent with information regarding the total costs as well as the income for each separate medical service that gives rise to revenue.

Income should be classified on the general accounting records according to the revenue producing services. Any fairly complete classification of expenses, whether by administrative divisions or by commodities and services may be used.

The bases to be used in allocating each group of expenses to revenue producing departments should be determined by the superintendent, department heads and accountant together. Periodically, preferably quarterly or semiannually, the fractions of each expense to be allocated to each revenue producing department should be computed from data relating to the bases selected.

The expenses as they appear in the general ledger should be listed in one column, and columns of a columnar sheet should be assigned to each revenue producing department. The expenses should then be allocated to revenue producing departments on the basis of the fractions already computed. The column total for any revenue producing department will be the amount of the estimated cost of that department.

Simplified Modern Accounting

John M. Peirce, California Taxpayers' Association, Los Angeles

Realizing that the county hospitals of California have no standard system of record keeping, our organization has been active in preparing such a system. First, we sought the advice and counsel of a representative group of hospital administrators in the state.

We have developed a system that we feel is simple enough to be adaptable to the smaller institution and yet capable of expansion into any degree of detail. The system has been used by each of the five administrators who helped devise it, and, by trial and error method, it has passed through many changes before reaching its present form.

The purpose of the plan is not to replace the set-

up used by the county auditors, but to supplement it. The plan is a matter of internal cost accounting and reporting and need not have a definite bearing on the financial accounting records maintained by the auditor. This system is intended as a tool of management and not as a means of general financial control.

The proposed plan consists of five parts, as follows: (1) the preparation of a manual of definitions; (2) the preparation of a uniform classification of expenditures; (3) the segregation of expenditures according to the types of service rendered, that is, acute medical and surgical, tuberculosis and chronic and custodial; (4) the issuance of an annual report to be submitted by each hospital to the State Department of Social Welfare, and (5) the compilation and publication of these reports in summary form by the State Department of Social Welfare.

Bed Occupancy in Canadian Hospitals for 1931

Dr. G. Harvey Agnew, Canadian Medical Association, Toronto

Since complete figures on bed occupancy for 1931 are not yet available, the analysis covers only 115 public general hospitals with a total of 10,733 beds, representing 29.4 per cent of the total public general hospital beds.

The average daily occupancy for this group for 1931 was 60.1 per cent. For the same representative group for 1930 the occupancy was 65.2 per cent. There was a falling off both in the number of patients and in the collective days' stay in every province but Quebec, where both items were increased.

Practically all of the public general hospitals in Canada, whether under private trust or municipal direction, have both public and private accommodations. So-called private hospitals are a comparatively small factor in Canadian hospitalization data. The percentage of patients in public hospitals who occupied private or semiprivate accommodations was 34.7 per cent in 1931, as compared with 36.5 per cent in 1930.

A study of seven large representative city hospitals reveals an alarming drop in private patient-day percentages, especially when it is remembered that these hospitals give public ward service at prices considerably below actual cost, Doctor Agnew stated.

With respect to the payment for treatment, the figures for 1930 indicate that 53.3 per cent of the total days' treatment was paid for, 19 per cent was partly paid for, and 27.7 per cent was given gratis.

The annual reports of the various sanatoriums show that practically all of them have been operating at capacity and that many have long waiting lists. There has been a large shrinkage in the number of private patients, according to the reports.

Dr. W. L. Babcock, who presided at the general session on economic problems.

The seven hospitals created for the care of ex-service men recorded more hospital days for 1931-32 (678,124) than for the period 1929-30 (668,947) and almost as many as for the intervening year (766,120).

The Canadian National Committee for National Hygiene reports a total of 32,662 inmates in mental institutions at the end of 1931, as compared with 31,052 inmates at the end of 1930. These figures do not include some 1,150 mental patients in the county homes in Nova Scotia.

Economical and Efficient Hospital Planning and Construction

Dr. William H. Walsh, Chicago, and Edgar Martin, Chicago

The paper gives many excellent suggestions for those planning a new hospital program and propounds sound principles that should govern procedure prior to hospital construction so as to ensure intelligent execution, low cost and efficient results.

The factors to be considered are discussed under various headings.

1. No new project should be inaugurated with-

Rev. Maurice F. Griffin, who stressed the need for government aid in caring for the indigent.

out determining the exact needs of the community by means of an analytical survey of local conditions. The findings of the survey should be submitted to an unbiased community agency and should be studied by the governing board of the hospital.

2. Sound logic should dictate the choice of an architect. Hospital architecture is a specialty and must be approached from the functional standpoint, the study of elevations and exteriors being delayed until the floor plans are worked out. A specialist in hospital design should be employed so that costs may be reduced without sacrificing quality.

3. A qualified consultant is an important factor in economical planning and his rôle does not conflict with that of the architect. He should possess extensive experience of hospital administration, an appreciation of community needs, and knowledge of technical details of hospital functions. He should be familiar with the architectural and mechanical problems involved. He must have the ability to coordinate his knowledge and interpret it in a way that will be intelligible to the architect.

4. Prudence should be exercised in obtaining an advantageous location for the hospital.

5. Planning should proceed by stages. First, preliminary studies should be made by the hospital building committee, the professional staff, the institutional personnel, the architect and the engineers, and all of these should be coordinated by the consultant. Second, when general agreement has been reached, the working drawings and specifications should be prepared. Third, estimates should be received, contracts let and operations started.

What Is Quality Nursing?

Adda Eldredge, Bureau of Nursing Education, Madison, Wis.

Quality nursing is cooperation with the physician and the family in care of the patient that produces the following results: (1) assists the patient to an improved state of health; (2) increases the patient's physical and mental comfort during illness; (3) assists the patient to avoid recurrence of his illness, and (4) raises the norm of physical and mental health.

These ends must be accomplished with the maximum of safety and comfort to the patient, the minimum expenditure of time and effort by the nurse, a maximum economy in the use of supplies, and a maximum harmony in relations with the hospital or the home where the patient is staying.

These standards may be obtained by careful selection of a prepared nursing personnel, and by the education of the nurse and the control of those elements tending to destroy nursing ideals.

Failures to obtain quality nursing are due largely to the following: (1) lack of correlation; (2) too great lapse of time between teaching and doing; (3) technique not carried over to the ward; (4) a difference in ward and private room technique; (5) lack of supervision of students after the first semester; (6) the teaching of advanced nursing techniques instead of nursing in medicine, surgery, obstetrics and gynecology, which accentuates more techniques rather than applied techniques; (7) lack of a properly trained supervisor, lack of time for preparation by both classrooms and ward instructors, and lack of time for carrying out details by students and graduates.

Recommendations of the Committee on Hospital Occupancy

Chairman, C. Rufus Rorem, Julius Rosenwald Fund, Chicago

The report of the Committee on Hospital Occupancy contains a number of recommendations for helping solve the problem of hospital occupancy. The committee explains that it does not expect its recommendations to be applicable to all hospitals; neither does it claim originality for all its recommendations. Their value lies, the report states, in the fact that the recommendations are the result of experiences of hospital administrators.

The committee's recommendations follow:

1. The operating reports of individual hospitals should contain statements showing the percentage of occupancy of the hospital beds subdivided according to the various types of services.

2. Hospital financial records and reports should segregate all fixed charges from operating costs.

3. Cost per patient day should be calculated on a comparable basis by hospitals.

4. Insofar as possible hospitals might well correlate the costs and incomes of the various revenue departments, such as board and room, x-ray and laboratories.

5. There should be community control of hospital construction and operation.

6. Governmental subsidy of private nonprofit institutions should be enlisted where voluntary contributions do not suffice for the charitable services rendered to the public.

7. Hospital facilities should be used to a greater degree by the medical profession.

8. There should be an increased use of fixed periodic payments in the purchase of hospital care.

9. There should be closer interrelation between physicians' fees and hospital fees.

Lowering or Adjusting Hospital Rates

Egbert E. Stackpole, Holyoke, Mass.

The weaknesses of present methods of establishing hospital rates were reviewed by Mr. Stackpole, who then turned to a consideration of ways to correct the evil.

He stated that the keynote to a solution of the problem is the adoption of a balanced financial budget, and that this involves determining the amount of income from all sources available for operating expense, including: income from restricted endowment, income from unrestricted endowment, donations from annual free beds, unrestricted donations and cash receipts from patients.

The total of the first four items is the amount available for free service. This sum, divided by the per capita cost, indicates the number of free days of service that may be given. Cash receipts from patients, added to the amount available for free service, gives the total sum available for operating expense.

The expense side of the budget must be adjusted to conform with the total available for operating expense, according to Mr. Stackpole.

Interest and depreciation on plant investment and taxes are not included in the operating costs of most hospitals; therefore the per capita cost is computed on the basis of current operating expense.

"The question of how much teaching and research expense should be included in per capita cost is debatable," Mr. Stackpole said. "There is, however, no question but that school of nursing costs should be included." He feels it is highly desirable for hospitals to establish a rate that will approximate costs, and to give each patient to understand that he is expected to pay this rate if financially able to do so.

Nursing Education and the Hospitals

Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y.

Doctor Munger described at considerable length the position of both the nursing profession and the administrators of hospitals upon a question vital to both groups—the education of the nurse.

Much of his material was based on the report of a special committee on nursing of the New York State Hospital Association of which he was chairman.

Doctor Munger is of the opinion that this problem, like many others, will be largely decided by economic forces. He presented a series of recommendations which, if followed, he believes should tend to bring the desired changes more quickly.

These recommendations are:

1. That immediate action be taken to control overproduction of nurses through omission by

Michael M. Davis, chairman of committee to study reports of Committee on the Costs of Medical Care.

schools of one of the two preliminary classes accepted each year until such time as the problem may have adjusted itself.

2. That schools now unable to maintain proper educational standards either close or make the school acceptable (a) by securing funds through endowments, public subsidies or private gifts; (b) by increasing the tuition fees of students sufficiently to meet increased financial demands, or (c) by decreasing the size of the school.

3. That when possible two or more schools in the same community establish central arrangements for instruction wherever such a plan would increase the educational advantages or decrease expense or both.

4. That every hospital board and superintendent, in conscientious conference with the officials of the school of nursing, consider whether the continuance of the schools be justified, and if found not justified, discontinue the school as promptly as possible.

5. That schools take no direct responsibility for placement of their graduates, but that continued inability of graduates of a school to obtain employment be considered as a strong point in favor of discontinuance or reduced enrollment.

6. That all concerned not only agree that the nursing school should be a purely educational project but that they act in accordance with that belief in connection with their own schools.

7. That when state curriculums are reviewed thought be given to the problems of the smaller schools and that a decision to approve or disapprove a school be based partially upon the effect that such approval or disapproval would have upon the local community.

8. That all concerned resolve to study each problem involving nursing education with an open mind and with a realization that these problems will eventually be solved by economic forces if they are not sooner solved by intelligent action in the field itself.

The Work of the Children's Fund of Michigan

Dr. Bernard W. Carey, Children's Fund of Michigan, Detroit

The Children's Fund of Michigan was established in 1929 by a grant of ten million dollars from Senator James Couzens. The deed of gift specifies that it shall be expended for the health, welfare, happiness and development of children in Michigan and elsewhere in the world.

The present program is divided into five main divisions: child health, child guidance, research, material relief and miscellaneous grants.

It is primarily a program of health education. Five health department units with full-time personnel consisting of a health officer, a dentist, nurses, a sanitary officer and a clerk bring to sparsely settled districts of several counties the same health advantages enjoyed by most urban areas.

Nurses work in thirty-two rural counties in a generalized nursing program. Twenty-two dentists and four dental hygienists are employed full time and twenty additional dentists are employed for thirteen weeks in the summer. Two ophthalmologists examine the eyes of school children, and glasses are given to the indigent. Two women physicians go to each county for three months, holding classes of instruction for mothers and examining infant and preschool children.

The division of child guidance is in its own building in Detroit. Children referred by doctors and various social agencies as being in need of social adjustment are diagnosed and treated there.

Report of Bed Occupancy in the United States for 1931

C. Rufus Rorem, Julius Rosenwald Fund, Chicago

There is always a great difference in the percentage of occupancy among hospitals of the same type and among various classes of institutions. For example, during the calendar year 1931 the hospital beds of the United States were occupied to 80 per cent of their registered capacity, but the rate was 95 per cent for nervous and mental hospitals and 64 per cent for general hospitals. But an average 64 per cent occupancy for general hospitals does not reveal the wide variations among institutions of different sizes and control.

A survey of the general hospitals in fifteen representative states in 1931 revealed several interesting and distinct tendencies. In the first place, governmental hospitals were more fully occupied than those not under government control. Eighteen hundred and two hospitals were included in the survey, representing about 45 per cent of the general hospitals and bed capacity in the country, and an average occupancy of 66 per cent. For the 86 federal hospitals covered by the survey the percentage of occupancy was 68 per cent; for the 238 state and local government institutions, 78 per cent, and for the 1,478 general hospitals under nongovernmental auspices, 61 per cent.

The large hospitals were more fully occupied than the small ones. Among the state and local government institutions, those with twenty-five beds or less reported 48 per cent of occupancy, in contrast to 83 per cent for hospitals with more than 300 beds. Similarly, the nongovernment hos-

pitals with twenty-five beds or less showed only 46 per cent of occupancy in 1931, compared with 68 per cent for institutions with more than 300 beds.

Metropolitan hospitals and those in industrial states maintained higher percentages of occupancy than those in smaller cities or rural states, particularly those under nongovernment auspices. Nongovernment hospitals in New York State reported an average occupancy of 68 per cent; New Jersey was second with 67 per cent. Mississippi, on the other hand, reported that 58 nongovernment hospitals were occupied to but 35 per cent of capacity in 1931. For the sixteen Wyoming hospitals the ratio was 40 per cent.

The Relation of the Wyoming County Hospital With the State

W. A. Copeland, Wyoming County Community Hospital, Warsaw, N. Y.

A law was enacted in New York State in 1923 permitting state aid to general hospitals that were constructed or acquired by the governing board of any county, town, city or village. The law stipulates that the service, administration and work must comply with such standards as the commissioner of health shall prescribe.

In 1930 the Wyoming County Community Hospital, at that time a private institution, was faced with the danger of closing because of a large deficit. The board of supervisors became the first to take advantage of this law by purchasing the hospital property in 1930. At the end of that year the board was reimbursed by the state to the extent of 50 per cent of the purchase price.

The deed to the property is held by the County of Wyoming, and the institution is controlled indirectly by the board of supervisors, who in turn appoint a board of managers. The managers appoint a superintendent and a medical advisory board.

The financial function of the set-up is unusual. The collections and receipts are turned over to the county treasurer. All bills and claims against the hospital are made up in the form of a voucher, and after being certified are passed on to the board of supervisors for payment. The deficit is determined at the end of the year and sent to the commissioner of health for approval. The county is then reimbursed for 50 per cent of the deficit.

We have four full-time men on the house staff who confine their practice to within the hospital. The attending staff refer their patients to our house staff. The members of the attending staff have the privilege of taking care of their own patients in the hospital, but cannot do major surgery.

Out-Patient Departments for Small Hospitals

O. N. Auer, Monmouth Memorial Hospital, Long Branch, N. J.

Valuable pointers on how to establish an out-patient department for a small hospital and some helpful suggestions for the organization and running of such a department were offered by Mr. Auer.

Before establishing an out-patient department, he suggests that the administrator analyze the

Dr. Winford H. Smith, who was elected a trustee of the association.

community to be served from the standpoint of (1) present occupancy of general ward accommodations; (2) other facilities already present in the community for doing the job; (3) present use of relief agencies by residents of the community; (4) amount of gratis service now being performed by the medical profession in their offices and in patients' homes, and (5) type of occupation of the majority of persons who would use the out-patient department.

He said the administrator should consult his board of directors, medical men in the community, social agencies, public health organizations and public-spirited citizens.

He remarked that a careful study should be made to determine: (1) the types of clinics needed by

the community; (2) whether adequate medical service is available to man such clinics; (3) whether any particular types of ambulatory cases are undesirable; (4) whether the clinic shall be free, part pay or full pay; (5) the basis upon which patients will be accepted for treatment, and (6) whether there is to be any restriction as to color, race, religion or residence.

Among the suggestions offered in regard to organization were: (1) hire an experienced department head; (2) keep in mind that the out-patient department has three functions, namely, care of the sick, protection of public health and teaching of physicians and nurses; (3) provide good equipment for the physicians; (4) combine the facilities of hospital and clinic ; (5) make clinic service a stepping stone to appointment on hospital medical staff; (6) appoint at least two men on each clinic, and (7) handle admission to the general wards by the same department or interviewer as in the clinic.

State, County or Municipal Subsidy for Indigent Patients in Private Hospitals

Rev. Maurice F. Griffin, Cleveland

In most cities tax funds are being raised for the care of the indigent, and so far as my experience goes these funds are available for the care of the indigent sick as well as other indigents, provided they are approached in the right way.

The hospitals must learn from others who already get public funds how to get a share of these appropriations. Friends of the hospital who are influential citizens of the community must be organized, help must be sought from the politicians who are controlling the situation and it may be necessary to engage lawyers in order to get this money. Just because you have every right in the world to this money does not mean it can be obtained without a fight.

Sometimes I think we have failed to take care of our legislative needs because we like to consider ourselves "charitable" institutions, which is one of our strongest appeals for funds. Most of us get the money for our free work from pay patients. In the name of charity we overcharge one man in order to take care of another man for nothing.

The common people have no obligation to carry the burden of the charitable activities of your institutions. When they paid their taxes they paid for this service.

I venture the assertion that 95 per cent of the free work would be paid for by governmental agencies, welfare federations, insurance associations or fraternal organizations, if the proper procedure were followed.

It is a fundamental function of government to provide for the general welfare. We are assuming a generally accepted governmental obligation and relieving governmental agencies of the proper function when we try to provide free care for the indigent poor.

Reduction in Expense *vs.* Loss in Income

Albert W. Buck, New Haven Hospital, New Haven, Conn.

Commenting on the problem facing hospitals as a result of reduced income, Mr. Buck said that the budget control plan used by his institution was extremely helpful during the past fiscal year in determining where expenditures were too high. He cited several examples of endeavors on the part of his hospital to cut expenses, and in this connection said, "the problem requires practical study constantly and there are no rules applicable to all hospitals and institutions."

The New Haven Hospital has not as yet reduced its employees' salaries, but each member of the organization has been notified that a reduction will be made on January 1, 1933, unless operating expenses are reduced sufficiently to make wage cuts unnecessary. Mr. Buck stated that this notice has already produced splendid results.

Automatic stokers have been installed in one of the hospital's plants, with the result that nearly $7,000 was saved on the year's coal bill, after allowing for the lower price of coal. A survey of another plant showed that it was possible to reduce wattage in certain lamps without affecting those used for reading purposes. This resulted in a saving of approximately $4,000, due to a reduction in the amount of current consumed and due to lower cost of lamps.

Since food accounts for nearly one-fourth of the operating expense of a hospital, this should be one of the most vulnerable sectors in any attempt to reduce expense, Mr. Buck stated. He feels that inasmuch as only a small percentage of the meals served in a hospital are special diets, more attention should be given to the method of serving the regular meals. The New Haven Hospital has engaged a dietitian who is experienced in directing the purchasing, preparation and serving of food on a large scale, commercial basis. Associated with this dietitian are persons equipped to prepare special diets.

In order to eliminate frequent absences from duty by laundry workers, a bonus is paid those workers who report for work every day. In addition, the scale of pay for the workers has been raised to the level of pay in commercial laundries. As a result, the hospital's laundry is now doing more work at less cost.

Round Tables Prove Popular at Protestant Meeting

CHARLES S. PITCHER, superintendent, Presbyterian Hospital, Philadelphia, is the new president-elect of the American Protestant Hospital Association which held its annual meeting September 9-12 at the Hotel Statler, Detroit.

A most instructive program was presented by this group on Friday afternoon when Clarence Baum, superintendent, Lake View Hospital, Danville, Ill., and Dr. Herm. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis., both gave excellent papers on economic conditions.

Charles S. Pitcher, the new president-elect.

On Friday evening the president, Dr. A. O. Fonkalsrud, superintendent, General Hospital, Mansfield, Ohio, delivered his address which was in the form of a general resumé of hospital conditions throughout the country, tinged with a note of optimism which added great value to his talk. The only other speaker on the Friday night program was John A. McNamara, executive editor, THE MODERN HOSPITAL. Mr. McNamara spoke for fifteen minutes on the value of public relations to hospitals, and outlined the scheme sponsored by the committee on public relations of the American Hospital Association and THE MODERN HOSPITAL Publishing Company's supplementary plan. An informal reception followed the Friday night program.

Saturday morning's program was in the form of a very practical round table conducted by Rev. Edward F. Ritter, superintendent, Robinwood Hospital, Toledo, Ohio. Laundry, engineering, housekeeping, food problems and other subjects were freely discussed by those present. Hospital legislation was also explained at this time by A. M. Calvin, executive secretary, Midway Hospital, St. Paul, Minn. The second round table was conducted by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., in which the economics of hospitals were minutely discussed.

Doctor MacEachern Conducts Round Table

Saturday afternoon's program opened with a symposium on nurses' training and the present nursing school problems. Joseph R. Norby, superintendent, Fairview Hospital, Minneapolis, Minn., told of the problems that he had faced during the past year and the standards that must be maintained. Elizabeth Pierce, formerly superintendent, Children's Hospital, Cincinnati, related the results of a questionnaire on the standards of nursing service and special speakers discussed both of these papers. Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, then proceeded with an exceptional round table, mostly on professional questions, such as the admission of patients, major surgery, operations, laboratory examinations and autopsies.

On Monday morning the membership committee reported and there was a general round table conducted by Robert E. Neff, administrator, University Hospitals, Iowa City, Iowa. At the end of this session Rev. Thomas A. Hyde, superintendent, Christ Hospital, Jersey City, N. J., was introduced as the new president for the coming year. Albert G. Hahn, business manager, Deaconess Hospital, Evansville, Ind., was again reelected treasurer.

PROGRAM OF THE A. C. OF S. HOSPITAL STANDARDIZATION CONFERENCE

Jefferson Hotel, St. Louis, October 17-20

Monday, October 17, 10:00 A.M.

Presiding Officer

Dr. Allen B. Kanavel, Chicago, President

Address of Welcome.
Dr. Curtis H. Lohr, hospital commissioner, department of public welfare, St. Louis.
Greetings.
Dr. J. Bentley Squier, professor of urology, Columbia University College of Physicians and Surgeons, and president-elect, American College of Surgeons.
Analysis of Findings From the Fifteenth Annual Hospital Standardization Survey and Official Announcement of the 1932 List of Approved Hospitals.
Dr. Franklin H. Martin, director general, American College of Surgeons, Chicago.
The Standardized Hospital as a Medical Education Center.
Dr. Allen B. Kanavel, professor of surgery, Northwestern University Medical School, Chicago.
Discussion.
Dr. Horace J. Whitacre, consulting surgeon, Veterans' Administration Hospital, Tacoma, Wash.
The Changing Relationship of the Doctor to His Workshop.
Dr. G. Harvey Agnew, secretary, department of hospital service, Canadian Medical Association, Toronto.
Discussion.
Dr. William D. Cutter, secretary, council on medical education and hospitals, American Medical Association.
Medical and Hospital Economics.
Dr. Daniel Crosby, attending surgeon, Fabiola Hospital, Oakland, Calif.
Discussion.
How the Hospital Management and Medical Staff Can Cooperate in Reducing the Mortality Rate of Appendicitis.
Dr. John O. Bower, clinical professor of surgical research, Temple University School of Medicine, Philadelphia.
Discussion.
Dr. George David Stewart, professor of surgery, University and Bellevue Hospital Medical College, New York City.
Oxygen Therapy in Hospitals, Equipment and Management of Service.
Dr. William Thalhimer, director of laboratories, Michael Reese Hospital, Chicago.
Discussion.
Dr. George W. Crile, director, Cleveland Clinic Foundation, Cleveland.

Monday, October 17, 2:00 P.M.

Presiding Officer

Dr. Allen B. Kanavel

Pertinent Problems Affecting Hospitals and Their Solution—From a Nationwide Survey.
E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis.
Discussion.
Dr. W. Hamilton Crawford, superintendent, South Mississippi Infirmary, Hattiesburg, Miss.
Economic Conditions as Affecting Canadian Hospitals and How They Are Being Met.
Arthur J. Swanson, superintendent, Toronto Western Hospital, Toronto, Ont.
Discussion.
Dr. Ross Millar, director of medical services, department of pensions and national health, and vice president, American College of Surgeons, Ottawa, Ont.
Cooperation of Hospital Boards and Hospital Executives with Medical Staffs in the Diagnosis and Treatment of Cancer.
Dr. Burton J. Lee, clinical professor of surgery, Cornell University Medical College, New York City.
Discussion.
Dr. Bowman C. Crowell, associate director, American College of Surgeons, and director of clinical research, Chicago.
Follow-Up and Study of End Results as Carried on by the Mayo Clinic.
Dr. Alfred W. Adson, professor in neurosurgery, Mayo Foundation, Rochester, Minn.
Discussion.
Fusing the Triple Viewpoints on Nursing—Doctors', Nurses' and Hospital Executives'.
Mary M. Roberts, editor, the *American Journal of Nursing*, New York City.
Discussion.
Dr. Donald Guthrie, chief surgeon, Guthrie Clinic and Robert Packer Hospital, Sayre, Pa.

Basic Standards for Schools of Nursing.
The Rev. Alphonse M. Schwitalla, S. J., dean, St. Louis University School of Medicine, and president, Catholic Hospital Association.
Discussion.
J. Dewey Lutes, superintendent, Ravenswood Hospital, Chicago.

Monday, October 17, 8:00 P.M.

Presidential meeting, Ballroom Jefferson Hotel. All hospital delegates are invited to attend.

Tuesday, October 18, 10:00 A.M.

(To Be Held at Tuttle Memorial Auditorium)

Dr. Louis H. Burlingham, superintendent, Barnes Hospital, St. Louis, presiding.
Depression Developments in Relation to Hospital Economics.
Dr. B. C. MacLean, superintendent, Touro Infirmary, New Orleans.
Symposium—Efficiency and Economics as Applied to:

(a) The Clinical Laboratory: Dr. J. J. Moore, director National Pathological Laboratories, Chicago.
(b) The X-Ray Department: Dr. Edward H. Skinner, Kansas City, Mo.
(c) The Physical Therapy Department: Dr. John S. Coulter, assistant professor and in charge of physical therapy department, Northwestern University Medical School, Chicago.
(d) The Administration of Anesthesia: Dr. Joseph McNearney, chief anesthetist, St. Mary's Hospital, St. Louis.
(e) The Administration of the Food Service: Eugenia Shrader, chief dietitian, Barnes Hospital, St. Louis.
(f) The Handling of Surgical Dressings and Supplies: Sister Philomena, supervisor of operating room, St. Mary's Hospital, St. Louis.

General discussion.
E. E. King, superintendent, Missouri Baptist Hospital, St. Louis.

Tuesday, October 18, 2:00 P.M.

(To Be Held at Tuttle Memorial Auditorium)

ROUND TABLE—ADMINISTRATIVE, PROFESSIONAL, ECONOMIC AND SOCIAL PROBLEMS

Conducted by Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison.

Tuesday, October 18, 8:00 P.M.

(To Be Held at Tuttle Memorial Auditorium)

JOINT SESSION FOR TRUSTEES, EXECUTIVES AND STAFF MEMBERS

Paul H. Fesler, superintendent and trustee, Wesley Memorial Hospital, Chicago, presiding.
Greetings from hospital trustees of St. Louis.
Aaron Waldheim, president, board of directors, Jewish Hospital, St. Louis.
Criteria to Be Observed in Selecting the Governing Body of a Hospital.
Dr. C. W. Munger, medical director, Grasslands Hospital, Valhalla, N. Y.
Discussion,
Responsibility of the Governing Body in Selecting the Superintendent.
Dr. C. G. Parnell, superintendent, Rochester General Hospital, Rochester, N. Y.
Discussion.
How Hospital Trustees Can Keep Abreast With the Advances in Hospital Administration.
Matthew O. Foley, editorial director, *Hospital Management*, Chicago.
Discussion.
Removing Hospitals From the Influence of Politics.
John A. McNamara, executive editor, THE MODERN HOSPITAL, Chicago.
Discussion.
Dr. E. P. Hogan, professor of gynecology and abdominal surgery, Graduate School of Medicine, University of Alabama, Birmingham, Ala.
General Discussion.
The Rev. R. D. S. Putney, superintendent, St. Luke's Hospital, St. Louis.

Wednesday, October 19, 10:00 A.M.

(To Be Held at Tuttle Memorial Auditorium)

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, Chicago, presiding.
Handling of Communicable Diseases in Connection With a General Hospital.
Henry A. Rowland, superintendent, Riverdale Isolation Hospital, Toronto, Ont.
Discussion.
Dr. Walter C. D. Kirchner, medical director, City Hospital No. 1, St. Louis.
The Individual Doctor's Responsibility for Clinical Records.
Dr. Walter F. Cole, chief, orthopedic departments, Sternberger Children's Hospital, Richardson Memorial Hospital, and St. Leo's Hospital, Greensboro, N. C.
Discussion.
Dr. Dewell Gann, Jr., professor of clinical gynecology, University of Arkansas Medical Department, Little Rock, Ark.

The Value and Scope of Medical Social Service Work in the Hospital.
Grace Beals Ferguson, assistant professor of medical social work, Washington University, St. Louis.
Discussion.
Robert E. Neff, administrator, University of Iowa Hospitals, Iowa City, Iowa.
How the Medical Social Worker Can Assist in the Present Economic Situation.
Ruth Lewis, associate director of social service, Washington University Clinics and Allied Hospitals, St. Louis.
Discussion.
The Rôle of the Social Worker in the Diagnosis and Treatment of Cancer.
Eleanor Cockerill, social worker, Barnard Free Skin and Cancer Hospital, St. Louis.
Discussion.
Dr. Frank L. Rector, field representative, American Society for the Control of Cancer, Evanston, Ill.
General discussion.
Dr. B. A. Wilkes, superintendent, Southeast Missouri Hospital, Cape Girardeau, Mo.

Wednesday, October 19, 2:00 P.M.
(To Be Held at Tuttle Memorial Auditorium)

ROUND TABLE—ADMINISTRATIVE, PROFESSIONAL, ECONOMIC AND SOCIAL PROBLEMS

Conducted by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex.

Wednesday, October 19, 8:00 P.M.

Community health meeting, to be held at St. Louis University gymnasium.

Thursday, October 20, 9:00 A.M.
(To Be Held at Jewish Hospital)

DEMONSTRATIONS AND ROUND TABLE CONFERENCES

Conducted by Robert Jolly and Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, assisted by E. Muriel Anscombe and hospital department heads.
Discussion and Demonstration of Preparedness for Emergencies in Hospitals.
Dr. Jerome Simon, resident, City Hospital No. 1, St. Louis, and Clara Coleman, superintendent of nurses, City Hospital No. 1, St. Louis.
Discussion of Operating Room Management With Demonstration of Detailed Procedure in Handling Major Operations.
Dr. Max Myer, director of surgery, Jewish Hospital, and Maria Dowler, surgical supervisor, Jewish Hospital, St. Louis.
Discussion of Food Service With Demonstration of Various Types of Tray Set-Ups, General and Special or Therapeutic Diets.
Dr. Llewellyn Sale, president, medical staff, Jewish Hospital, and Bethel Curry, head dietitian, Jewish Hospital.
Discussion and Demonstration of Handling Supplies.
Florence King, Jewish Hospital.
Staff Education With Demonstration of Nurses' Conferences.
Edna E. Peterson, principal, School of Nursing, Jewish Hospital.

Thursday, October 20, 2:00 P.M.
(To Be held at St. Mary's Hospital)

DEMONSTRATIONS AND ROUND TABLE CONFERENCES

Conducted by Dr. MacEachern and Mr. Jolly, assisted by Mother M. Concordia and heads of departments of hospitals.
Discussion of Organization of the Hospital With Exhibition of Organization Charts.
The Rev. Alphonse M. Schwitalla, S. J., dean, St. Louis University School of Medicine, and president, Catholic Hospital Association.
Discussion of Admission of Patients With Demonstration of Complete Procedure.
(a) The medical aspects of the problem: Dr. Goronwy O. Broun, director of resident staff, University Hospitals, St. Louis, and (b) the social service aspects of the problem: Irene Morris, supervisor of medical social service, University Hospitals, St. Louis.
Discussion of Nursing Administration and Nursing Service.
Sister M. Henrietta, superintendent of nurses and associate director, School of Nursing, St. Mary's Hospital.
Discussion of Problems Associated With Clinical Records and Demonstration of Complete Record System.
Dr. E. Lee Shrader, director, St. Louis University Student Health Service, St. Louis.
Discussion of the Organization and Management of the Pediatric Division With Demonstration of Certain Procedures.
Dr. Julius A. Rossen, physician in charge, pediatric division, St. Mary's Hospital.

NURSING AND THE HOSPITAL

Conducted by M. HELENA MCMILLAN, R.N.
Director, School of Nursing, Presbyterian Hospital, Chicago

The Nursing Council—A Device to Balance Nursing Needs

By EMILIE G. SARGENT
Detroit Visiting Nurse Association

OUT of dire need, modern hospital nursing was born. It will be remembered that frightful and revolting conditions existed in hospitals prior to the introduction of the Nightingale system in the middle of the nineteenth century. There were no graduate nurses then, and students were introduced into the hospitals to care for the sick, a method found satsifactory at that time. It is the continuance of the Nightingale plan for the last seventy-five years that has brought about the present crisis in nursing.

Out of the needs of the sick poor in their homes, visiting nursing was born. This type of service was fostered by a layman, William Rathbone of Liverpool, and it should be noted that by 1859 trained nurses were available for this service. From the beginning, district or visiting nursing has been done by trained, later termed graduate, nurses. When the student nurse has been given experience in this field, it has been for the purpose of teaching her, not for the purpose of doing the work of the visiting nurses' association.

Why We Have Too Many Poor Nurses

The progress of civilization, including modern medicine and public health, has opened many new fields to nurses. It has also increased the number and kinds of hospitals, and these unfortunately have continued to use the student nurse method of caring for their patients. This is the simple explanation of the oversupply of poor nurses, which has been piling up for the last ten years. This lack of balance between demand and supply has bred dissatisfaction in all quarters—among nurses, doctors, patients and the paying public. Many methods of treatment have been prescribed, such as higher educational standards, fewer and better schools of nursing, new fields of service for the nurse, such as hospital group nursing, hourly appointment nursing, industrial nursing and other new forms of public health nursing. In trying to apply these remedies, organized nursing has discovered a fundamental question that should be answered before a balance of supply and demand can be expected. The question is simple—How much nursing does a community need? But no one knows the answer.

Measurement Data Are Lacking

Members of the A. N. A. committee on the distribution of nursing service have searched the literature, including community health studies made by the American Public Health Association, the United States Public Health Service, the Committee on the Costs of Medical Care and the Committee on the Grading of Nursing Schools, for data sufficient to answer the question. They have consulted authorities on measurement in community health, but there are no standards by which to estimate how much nursing is needed. There are studies that point to the number of hospital beds needed on a population basis and the desirable number of public health nurses needed. There is a wide variation, however, between the amount of nursing needed and the amount that will be used. Usage is limited by several factors, such as the purchasing power of the patient, or his knowledge of the value of skilled nursing and his desire to buy it, for he may be satisfied with the home grown variety given by the kindly relative or neighbor.

A constructive principle in nursing is to teach individuals how to take care of their own health

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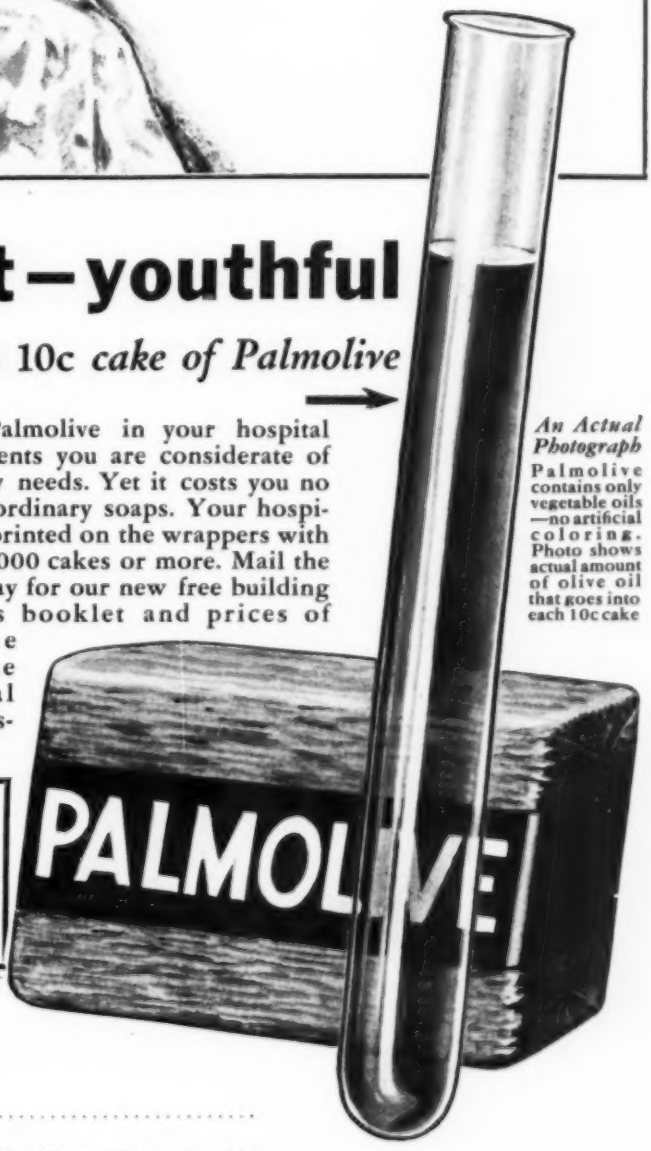

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and what to do for sick members of the family. One of the most important contributions to family health is the course in home hygiene and care of the sick given by the American Red Cross. The necessity for nursing service is thus eliminated in many families in which perhaps the mother has attended a class in home hygiene and care of the sick or the daughter has taken the course at school. It cannot be said that nursing needs are not being met if these amateur nurses are able to fill them.

Making Use of the Public Health Nurse

The American Public Health Association has stated that for the good of the community there should be one public health nurse to every 2,000 inhabitants. Those who have had the experience of sending a public health nurse into a new district where there are 10,000 people to the one nurse, know that it will take a good deal of educating before the people of that community learn to make use of the full time of one nurse. I recall an instance of this kind in which a progressive suburban town decided to have a community nurse. The city council voted an appropriation for her salary, having been convinced by a committee of women that to provide nursing care on a visiting basis for the very poor and the middle class was a civic responsibility. There were 9,000 people in this town, but the nurse had so little to do that she became discouraged and after a few months resigned. If her committee had done more to educate the community to make use of her services the result would have been different. Again and again it has happened that new communities in which visiting or community nursing service has been introduced and sponsored by an interested enthusiastic lay committee demand so much service that by the end of the first year three nurses were required. It should be noted that the demand did not occur spontaneously but was the result of the committee's publicity and the excellent work of the nurse.

The Beginning of a Great Movement

I should like to call attention to the teamwork implied in this illustration. If a group of interested women aided by a skilled public health nurse can create and increase the demand for nursing in their community, is it not reasonable to apply this principle to all nursing? Thus it is evident that community participation is one of the factors that will determine how much nursing will be used in a given locality.

From the benefits accruing to public health nursing through its lay boards and committee members, the Cleveland and Detroit councils on nursing were evolved, and from the benefits accruing to nursing education from training school lay committees, the program of the Chicago Council on Nursing Education developed. And from the lessons learned in these councils, a great movement has been started. For two years a committee appointed by the national nursing organizations has been studying the functions of councils on nursing. These organizations have adopted a form of community council which includes representation from all types of nursing service and nursing education and from the professional fields of nursing, medicine, hospital administration, education, social work as well as from lay trustees and public-spirited citizens. A model plan recommends that the council align itself with the council of social agencies, and if there is a health council become its committee on nursing.

In order to promote the nursing council plan on a national basis, committees were formed in each state nurses' association designed to aid the district or local nursing association to initiate a nursing council. Thus machinery has been put into motion that should help in the solution of the problem of how much nursing a community needs. This plan of organization is a step in the right direction, but it will take years for the movement to become general enough to be truly effective.

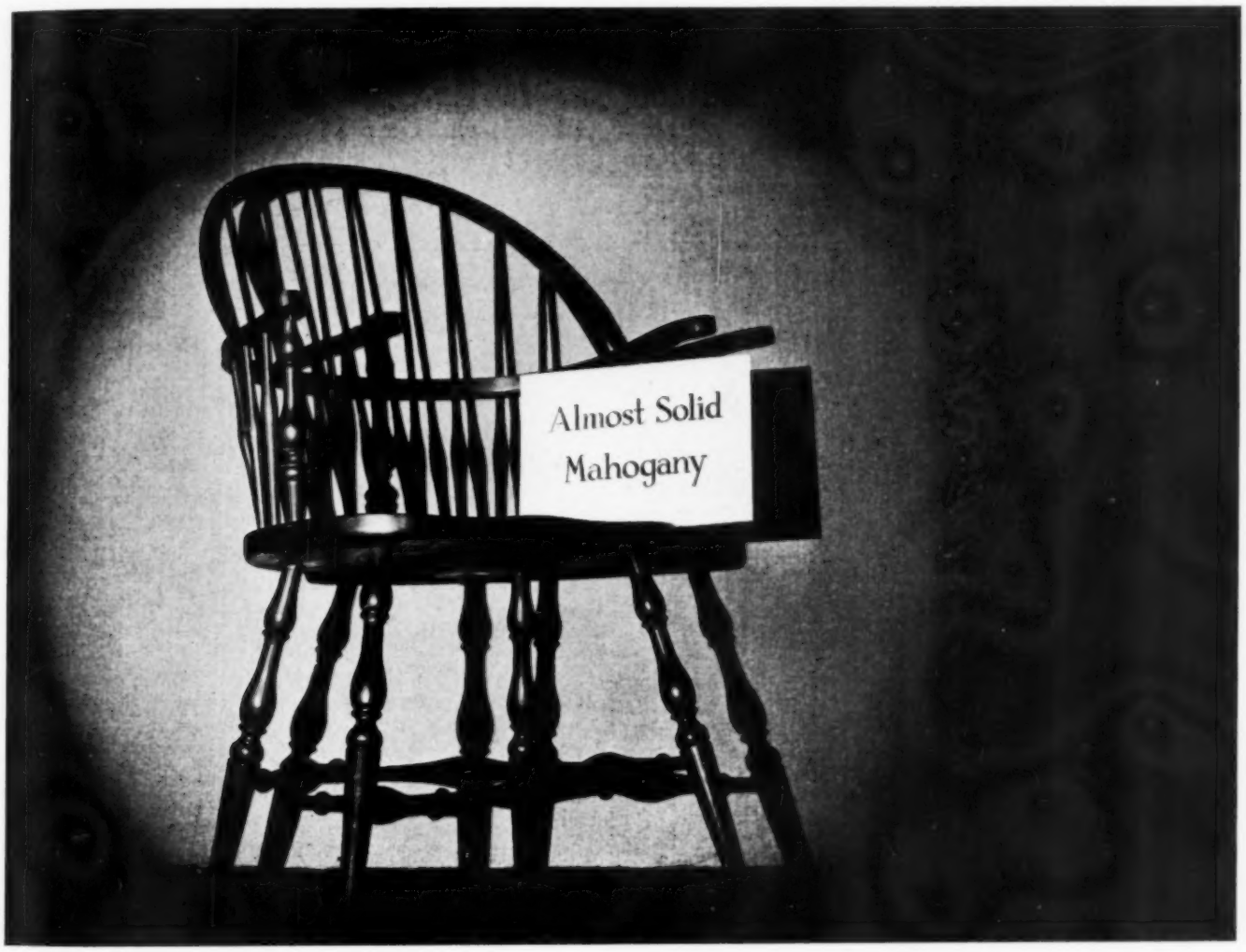
What One Council Has Accomplished

Existing councils have accomplished a great deal. For example, I need only cite the Chicago Council on Nursing Education, organized in 1920, which provides for institutional, organization and individual membership. Each hospital or organization employing nurses has a certain number of trustee delegates. This includes the superintendent of nurses or the director of the school of nursing. The mingling of hospital trustees and training school committee members with nurse leaders has accomplished a great deal in raising the standards of nursing education in Chicago and Illinois. The Chicago council has sponsored the hourly nursing experiment and the nurse placement service of the five Middle Western states. It will be easy for the Chicago council to enlarge its scope to embrace further community representation as recommended by the national committee.

The 1930 objectives of the Cleveland council are stated as follows: (1) to coordinate as far as possible the various nursing organizations of the city; (2) to maintain equal standards of high professional training as a requirement of all the organizations represented; (3) to provide a meeting ground for the discussion of matters affecting nursing service from the point of view of the public served and of the nurses giving service; (4) to promote efficiency and economy in the provision

"Just as good" never is

The imitator always apologizes. By imitation he is silently approving another man's work and automatically taking second place. The statement "just as good" is a confession of weakness. Beware of a product whose only endorsement is a claim to a prestige held by another.



There are imitations of the Ideal Food Conveyor. There are food carts that look very much like an Ideal unit — in size, general appearance, color and finish. But the Ideal itself cannot be duplicated. Many of the features of the Ideal are exclusive — protected either by license or our own patent rights. Many points of construction cannot be matched by small manufacturers with facilities equal to ours. No maker can build and profitably sell a food conveyor unit for as little money as we can. Don't be influenced by talk of lower price — for there is no lower price, merit considered, than the Ideal price. That's why most food conveyors are Ideals.

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of personnel to staff the various organizations, and (5) to make the experience of one group available for the use and benefit of all.

The Detroit council, organized in 1917, obtained the establishment of a department of nursing in the Detroit City College, which provided a course of instruction and field supervision for practical nurses, and the establishment of a joint hourly nursing service by the Detroit District Nurses' Association. The Detroit council has not been satisfied with the amount of hourly nursing used, and it is asking how much and what kind of nursing Detroit needs. A request for help in answering this question was made to the A. N. A. committee on the distribution of nursing service and, as has already been stated, this committee could find no existing standard by which a community can measure its nursing needs. The committee agreed that the answer entailed research on the actual sickness in the community and a correlation of facilities with needs as indicated by sickness and that the importance of this project warranted an appeal to research foundations.

Communities need not wait to form councils until criteria for measuring sickness rates are developed. There is much to be gained from the coming together of the council representatives, as has been illustrated by the Chicago, Cleveland and Detroit councils. A first step will be to learn the programs of all agencies employing, registering or training nurses. From these data the council will be able to note glaring gaps and duplications that so often exist, because as a rule communities have not planned the development of their health work and it has grown up like Topsy.

Meeting Community Needs

Since nursing touches so many other professions —medical, public health, social service, education, nutrition—it is only natural that the members of these professions should be interested in helping to evolve a plan to meet community nursing needs. A nursing council provides an opportunity for its members to understand something of the work of each of the organizations that sends representatives, thus decreasing the possibility of duplication of existing programs and avoiding the setting up of unnecessary new work. It gives the members of the council, who necessarily must be interested in nursing service, an opportunity to be in on the ground floor of the work, which wins their confidence and their support. The local medical society or hospital association is not apt to be suspicious of nursing activities if it has representatives on this council, for most of the irritations that occur arise through lack of understanding. Such a body of informed public opinion would be useful to each of the member organizations. For example, the department of health would find the council helpful in combating political interference with its public health nursing program.

It is hoped that the understanding of mutual problems within the council will aid in better professional relationships between organized nursing, medicine and hospital administration. Each profession in its local, state and national groups might well have a joint committee on which both nurses and doctors serve. Physicians are interested in the education of the student nurse, and likewise nurses are interested in the education of the medical student.

The Scope of the Council

What has been said about the functions of the nursing council applies more particularly to the larger cities where there are many types of organizations offering nursing service, yet it also applies in principle to the small town and county areas. Here the form of organization would be less complex, but representation of all interests should obtain.

Through the nursing council a community can learn its nursing needs and how to meet them. The council studies the problem from the community point of view and not from the isolation of one organization's need, such as the hospital's compulsion to use student nurses instead of graduates because of financial limitations. The council will see that the community has an obligation not only to the hospital but to the student, and will find a way to solve the most perplexing problem confronting nursing and hospital administration today.

I have not answered the question, "How much nursing does a community need?" But I have told how I think the answer can be found and that is by means of the formation of a community nursing council.

A public aroused by the disclosures of the utter lack of nursing in the English army during the Crimean War made possible the changes that occurred in hospitals and in nursing under the leadership of Florence Nightingale. Today nursing needs an informed public opinion to make possible changes that must come to avert disaster and chaos. Community planning is the only satisfactory method of regulating any kind of public service in our complex civilization. The community nursing council is the device that will secure a balance between nursing needs and nursing service. This is not a one-year or a five-year plan, but one that should be used as long as humanity needs nursing.[1]

[1]Read at the Lay Institute of the Central Council for Nursing Education, Chicago.

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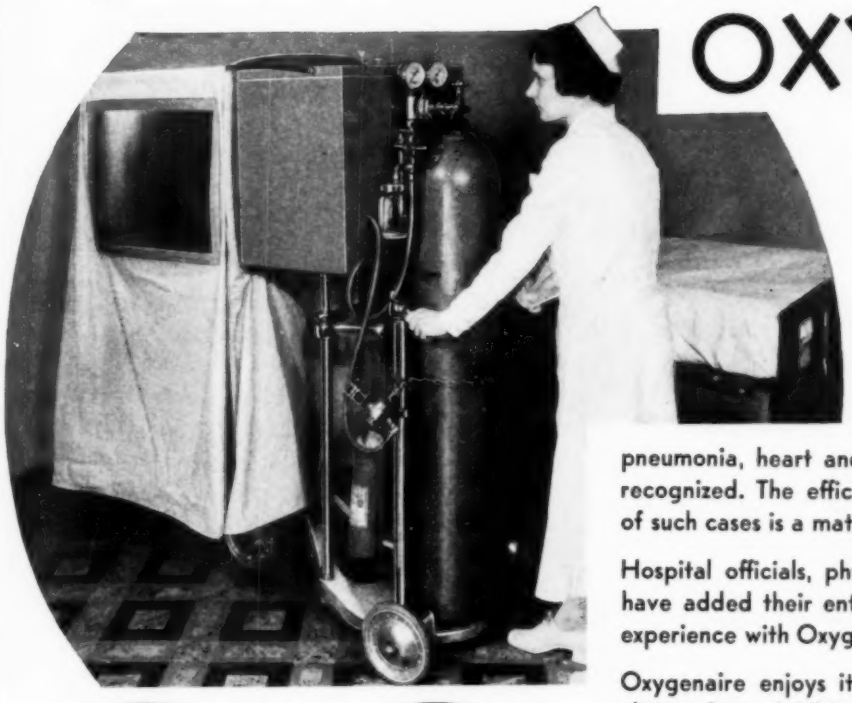

The value of Oxygen-Therapy in pneumonia, heart and post-operative cases is established and recognized. The efficiency of OXYGENAIRE in the treatment of such cases is a matter of record.

Hospital officials, physicians, heart and anaesthesia specialists have added their enthusiastic endorsement as a result of their experience with Oxygenaire.

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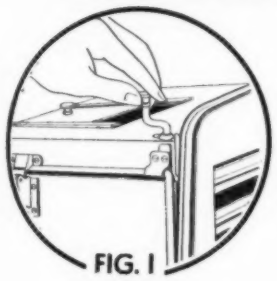

FIG. I

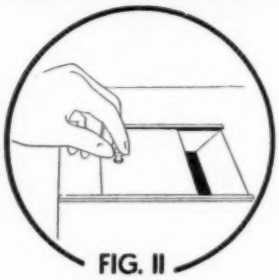

FIG. II

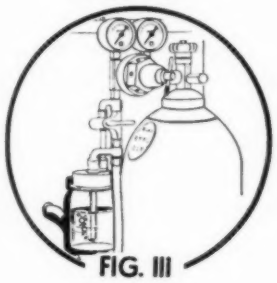

FIG. III

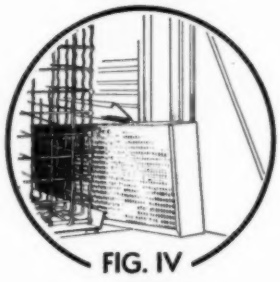

FIG. IV

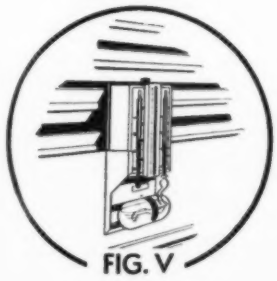

FIG. V

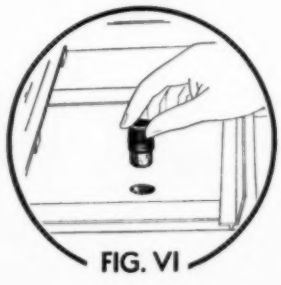

FIG. VI

◀ OUTSTANDING OXYGENAIRE FEATURES

I Shutter control, for regulation of air circulation, is operated easily by a single motion. With Shutters temporarily closed the tent loses none of its oxygen concentration or coldness. This feature is a decided improvement over former methods.

II The Ventilator in top of cabinet admits room atmosphere in any amount desired. With it open a patient may be treated to the cool, dry air in the tent, without use of oxygen.

III Oxygenaire's Sight Feed Control is a simple but infallible device. It is absolute protection to the user against otherwise undetectable interruption in the flow of oxygen.

IV Soda Lime Screen. This convenient, easily accessible device may be introduced across the circulation current at any time. Its use does not affect free circulation in any way.

V The Humidiguide, an exclusive Oxygenaire feature, is as practical as it is convenient. It records average tent temperature and relative humidity.

VI An especially designed Drain keeps the correct amount of ice water in the bottom of cabinet, as an aid to proper conditioning of the atmosphere.

Oxygenaire has eight other outstanding features that offer further proof of its superiority.

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NEWS OF THE MONTH

Dietitians Will Study Practical Problems at Meeting

THE American Dietetic Association has completed the program for its fifteenth annual convention, to be held in New York City, November 6 to 11, inclusive. Time has been provided on each day's program for inspection of the exhibits that will be on display.

Registration will be the first activity on the Monday morning program. The convention will formally open at eleven o'clock with a general session. Dr. Martha Koehne, University of Michigan, president of the association, will preside. Dr. Henry Sherman, Columbia University, New York City, will speak on "Recent Advances in Nutrition."

The annual business meeting will be held Monday afternoon, and the annual banquet will be held that evening. Doctor Koehne will preside at both of these functions. Dr. Lafayette B. Mendel, Yale University, and Dr. Mary Swartz Rose, Columbia University, will speak at the banquet.

The Tuesday morning session will open with a joint session of the social service and education sections. Laura Comstock and Dr. Mary deGarmo Bryan will preside. A program will be put on by the New York City Home Economics Association at the "flavor luncheon" Tuesday noon. Edith Barber, president of that organization, will be in the chair, and talks will be given by Mr. Sweeney, Hotel Statler, and May Van Arsdale, Teachers College, Columbia University.

Mary Lindsley, Washington, D. C., will preside at the general session on Tuesday afternoon. "Special Problems in the Administration of the Institution Food Unit" is the subject of an address to be delivered by Cora C. Colburn, Yale University.

Ten minute talks on food topics will be given by the following: Helen Stacey, special assistant, American Telephone and Telegraph Company; Harriet Stone, supervisor of nutrition, Newark Public Schools, Newark, N. J.; Adeline Wood, chief dietitian, Mt. Sinai Hospital, New York City, "Buying Meat, Study of Cuts"; Emma Holloway, supervisor of institutional courses, Pratt Institute, Brooklyn, N. Y., "The School Cafeteria as a Unit in Teaching Institutional Courses"; S. A. Larrison, refrigeration engineer, New York City.

Dr. Kate Daum, University Hospital, Iowa City, Iowa, will preside at the general session on Wednesday morning. Lucy Gillette, New York City, will speak on "Feeding the Family in an Emergency," and Dr. Alfred F. Hess, New York City, is scheduled to talk on "Taking Institutionalism Out of the Institution." Dr. Paul H. Howe, United States Department of Agriculture, will talk on "Problems of Feeding Federal Prisoners."

Will Inspect Nutrition Laboratories

The Wednesday afternoon program will open with a joint session of the diet therapy and the administration sections. Dorothy Stewart Wallers, University Hospital, Ann Arbor, Mich., and Faith McAuley, University of Chicago, will preside. This will be followed by a trip to Columbia University Nutrition Laboratories.

The general session opening the Thursday morning program will be presided over by S. Margaret Gillam, New York Hospital, New York City. Among the subjects on the program are "Food and the Mind," Dr. Earl Bond, Philadelphia; "Food Sensitiveness and Intolerance," Dr. Maximilian A. Ramirez, New York City, and "The Rôle of Diet in Tropical Medicine," Dr. T. T. Mackie, New York City.

Mary Pascoe Huddleson, editor, *Journal of the American Dietetic Association*, New York City, will be chairman at the general session on Thursday afternoon. Topics to be discussed are "Anemia Studies," Dr. Frieda S. Robscheit-Robbins, University of Rochester Medical School, Rochester, N. Y.; "Anemias: Clinical Study," Dr. Randolph West, Presbyterian Hospital, New York City, and "Present Status of the Ketogenic Diet and Its Use," Dr. Clifford Barborka, Chicago.

The program for Thursday evening includes "foreign dinners," theater parties and a midnight market trip.

On Friday, November 11, trips will be made to a number of local hospitals and medical centers.

NEWS OF THE MONTH (Cont'd)

Doctor Billings Dies

The death of Dr. Frank Billings, which took place September 21 at his home in Chicago, ended one of the most brilliant careers in Chicago's medical history. He was seventy-eight years old.

In addition to being for over forty years a medical practitioner of outstanding ability and success, Doctor Billings was instrumental in founding several of the city's hospitals, clinics

and research laboratories of inestimable value, through his own generous contributions to the cause and through his influence in obtaining gifts from men of great wealth, many of whom were his patients. Among these institutions may be mentioned the Billings Hospital, a family memorial to the late Albert Merritt Billings, uncle of Doctor Billings; the McCormick Institute for Infectious Diseases; the Sprague Institute for Research in Medicine at the University of Chicago and the Bobs Roberts Hospital for Children at the University of Chicago.

Doctor Billings was born at Highland, Iowa County, Wisconsin, and graduated in medicine at Northwestern University, Chicago, in 1881. He studied bacteriology in the great medical centers in Europe and in 1886 brought to Chicago its first bacteriologic outfit for cultivating bacteria. He was professor of medicine at Northwestern University from 1891 to 1898 when he joined the staff of Rush Medical College and in 1900 became dean of the faculty, a post which he held for twenty-five years. He was twice elected president of the American Medical Association, the only man to be elected more than once to that office. He was for many years physician in chief at the Presbyterian Hospital, and was founder of the Institute of Medicine in Chicago.

Doctor Billings' interest in medical and public health affairs was of national scope. He was associated with Doctors Osler, Trudeau, Welsh and Bowditch in founding the National Tuberculosis Association and in 1907 served as its president. He was also at one time president of the Association of American Physicians.

Although Doctor Billings retired officially from active participation in medical and hospital affairs in 1924 his moral leadership in the field continued until his death.

Ontario Hospital Association Plans Annual Convention

The Ontario Hospital Association has completed plans for its annual convention, to be held October 26, 27 and 28, at the Royal Oak Hotel, Toronto. This year's meeting will be the ninth annual convention of the association. A splendid program has been arranged and extensive educational and commercial exhibits will be a feature.

Colored Graduate Nurses Meet

The National Association of Colored Graduate Nurses held its annual convention recently in Nashville, Tenn. Mabel C. Northcross, St. Louis, was elected president.

The group will meet next year in Chicago.

PAINTABILITY . . .

The acid test of Permanence

Preparing and serving meals create noise. City Hospital, Providence, R. I., protects its patients by using Acousti-Celotex on the ceiling of the dining room to absorb sound. Architect: T. J. H. Pierce.

Acousti-Celotex assures exclusive advantages in SOUND absorption

ACOUSTI-CELOTEX ceilings can be painted repeatedly with any kind of paint without loss of sound absorbing efficiency—BECAUSE: the deep perforations cause sound to be absorbed *within the material* instead of at the surface.

It is this property (covered by exclusive Acousti-Celotex patents) that justifies the claim, for this material, of PERMANENCE.

A hospital, of all places, should be quiet. The high sound absorbing efficiency of Acousti-Celotex, predetermined and fixed by its patented perforations, corrects bad acoustics and produces a degree of quiet that cannot otherwise be obtained.

To enjoy this quiet no interruption of hospital routine is necessary. For remember, Acousti-Celotex is applied directly to the existing surface of the ceiling. It is not necessary to build a new hospital or remodel the present one to enjoy quiet now.

The job is quickly and easily done, whether in the corridor, kitchen, dining room or any other department where normal activities create noise.

Acousti-Celotex does not deteriorate, requires no repairs, is permanent. For full information write Acousti-Celotex Service Bureau, 919 N. Michigan Ave., Chicago, Illinois.

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NEWS OF THE MONTH (Cont'd)

Red Cross Makes Plans for Its Annual Roll Call

The annual roll call of the American Red Cross will be held from Armistice Day to Thanksgiving, November 11 to 24.

The American Red Cross is now entered upon its second half-century of service. During the last year it has aided more than ten million persons suffering because of tornado, flood, drought and other disasters and the added burden of unemployment. It has distributed throughout the states forty million bushels of wheat in the form of flour and feed for livestock.

The extraordinary demands of the last year have seriously depleted Red Cross resources. They must be replenished if the organization is to continue to provide the same helpful service.

The Red Cross is asking and expecting the loyal support of those who have aided it in the past.

J. A. M. A. Publishes Statistics on Intern Training

The educational number of the *Journal of the American Medical Association,* the issue of August 27, again presents statistics concerning intern education, based on information gathered from 676 hospitals that are approved for internships by the association's Council on Medical Education and Hospitals.

These approved hospitals now have places for 1,325 more men or women than the medical schools annually turn out, a situation that is a hardship for the institutions that are unable to secure adequately trained men or women as interns.

The *Journal* points out that this competition is impelling many hospitals to improve their facilities for intern training, and suggests that a solution of the problem may be found in the practice of using the same intern over longer periods of time, that is to say, extending the present almost universal twelve months' service to fifteen or eighteen months, thus bringing about a greater spread of interns.

Another suggestion offered is that the hospital world adopt the practice of contracting for intern services at different times during the year, so that there always will be a few experienced interns in whom confidence may be placed while the new group is becoming accustomed to new duties and hospital methods.

The *Journal's* survey presents interesting tables on the growth of internships; autopsy performance in approved hospitals; staff activities for interns; various duties required of interns, and other features of education of interns in approved hospitals. There is also included a complete list of the 696 hospitals, containing 221,174 beds, which the Council on Medical Education considers in a position to offer acceptable internships for medical graduates. The number of internships in these hospitals is 6,261.

New York City's Hospitals Cut Food Bill in 1933 Budget

In its budget request for $19,811,598 for 1933 the Department of Hospitals, New York City, asks $2,549,685 for food or $300,314 less than the same item in the current budget allowance.

The department has been enabled by lowered food prices, and by the introduction of "contact dietitians," to reduce the average daily cost of feeding each patient from 32½ cents a day in 1931 to an estimated 20 cents in 1933, it is explained.

The budget request furnishes estimates of the needs of the more than twenty hospitals under jurisdiction of the department.

The $300,314 cut in the food allowance is even larger than it appears on its face because the institutions are feeding 18,000 patients as against 16,000 last year. Figures for the 1933 estimates are based on prices as of June 30, 1932.

Not only are food costs lowered, but patients get largely the kind of food they like, through the "contact dietitians," young women who visit the wards and chat with each patient about his or her taste for food.

Through informal contacts, the dietitians learn the preferences of the patients and report to the head dietitian. Whenever possible the wishes of the patients are gratified and special dishes are prepared in the kitchens of different wards. The bulk of the food is prepared in the general kitchens and then served from the ward diet kitchens, where it is kept warm.

NEWS OF THE MONTH (Cont'd)

The new method of administering food eliminates the waste that would follow an untouched meal.

The new system was put into effect following the appointment of Dr. J. G. William Greeff as commissioner of hospitals. Before introducing the system, Doctor Greeff ordered a survey which convinced him that the new plan would result in economies.

Ella G. Ennis, director of dietetics, directs the diet for each hospital and supervises a staff that keeps an accurate check on the amount and cost of the food distributed. Costs are figured to the thousandth part of a cent. Competitive bidding is followed to get the lowest prices.

Dangerous Crowding in New York Hospitals, Trustee Holds

The municipal and private hospitals of New York City are so overcrowded with needy patients, and so irregularly located, that a definite menace to the health of future generations is impending, said Howard S. Cullman, president, Beekman Street Hospital, New York City, in upholding the negative side of a debate recently with Dr. J. G. William Greeff, commissioner of hospitals, New York City, upon the question, "Does the City Take Care of Its Sick?" The addresses of both speakers were broadcast.

The facilities of city operated hospitals are taxed to capacity, said Mr. Cullman, and an overflow of 50,000 patients are turned over to private institutions which are not sufficiently recompensed by the city for this service to keep them from the doors of bankruptcy. He urged a careful survey of the cost of each patient to the city so that hospitalization could be developed upon scientific lines.

While Mr. Cullman insisted that no expense should be spared in the interest of health during a time of depression, Commissioner Greeff maintained that the city is performing its medical tasks as well as could be expected, since it has been necessary to curtail to a large extent the $50,000,000 building program projected for the Department of Hospitals in 1930. The commissioner admitted that the daily average of patients cared for by the department in the first quarter of this year was 17,773, while the entire bed capacity of the department was 17,736.

New York-Cornell Medical Center Opened September 1

New York's newest medical center, the New York Hospital-Cornell Medical College, a $30,000,000 plant twenty-seven stories high, was opened to the public on September 1.

The group of buildings, eleven in number, on the East River between Sixty-Eighth and Seventy-First Streets, incorporates three New York City hospitals as well as the faculty and student units of the Cornell Medical College. The consolidation, effected largely through the efforts of the late Payne Whitney, brings together the New York Hospital, the Lying-in Hospital and the Manhattan Maternity Hospital.

When operating at capacity the buildings will accommodate 1,000 patients and there are facilities for serving an equal number of daily visiting patients.

Dr. G. Canby Robinson is the director of the joint administrative board of the organization.

Builds $226,000 Service Unit

The Homer G. Phillips Hospital (colored), St. Louis, has awarded contracts for construction of a new service building. The new building will cost approximately $226,000 and is to be finished within the next ten months.

"What's Happening to Hospitals?"

This query is presented by the publicity committee of the Hospital Association of Pennsylvania in a small booklet recently issued with the above title.

The text dwells on the economic plight of hospitals in general and considers specifically the load borne by Pennsylvania hospitals. Many tables are presented showing the total cost of free days of service given by various groups of hospitals in the state compared with the amount and percentage of this expense borne by the individual hospitals. What the hospitals have been doing to keep afloat and why they are still engulfed is told and the booklet is concluded with the statement that "somewhere, somehow, hospitals must find new or increased support—or give up their ideal of caring for all who apply."

The keen edges of Bard-Parker blades are often dulled by the injurious effects of boiling in water or immersing in corrosive sterilizing mediums. For the preservation of delicate cutting edges and all metal instruments, the Bard-Parker Company recommends BARD-PARKER *Formaldehyde* GERMICIDE. This solution, powerful and rapid in action, is non-injurious to metal instruments, rubber and glass. Complete description and reports of bacteriological tests sent upon request. Ask your dealer.

PRICES: Bard-Parker handles—$1.00 each. Blades, all sizes, 6 of one size per pkg.—$1.50 per doz. QUANTITY DISCOUNTS: 1 to 5 gross, assorted sizes of blades, unit delivery—10% discount. 5 gross or over, assorted sizes of blades, unit delivery—15%.

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NEWS OF THE MONTH (Cont'd)

A. H. A. Bond Issue Is Fully Subscribed

The $32,500 gold bond issue authorized recently by the board of trustees of the American Hospital Association has been already fully subscribed, it is reported.

The bonds, which were issued in denominations of $100, are secured by a first mortgage on the headquarters of the association in Chicago and bear 6 per cent interest from July 1, 1932, for a period of fifteen years. Provision has been made for amortization of the bonds at $2,166.69 per year, and bonds voluntarily offered for sale will be redeemed with the monies in the amortization fund up to and including the amount available in this fund at any time.

The bond issue was made in order to assist the board of trustees in its effort to turn over the association's piece of property within a few years, free of indebtedness, and as a permanent endowment for the improvement and advancement of hospitals.

New Clinic Will Be Erected by Hospital in Boston

The trustees of New England Deaconess Hospital, Inc., Boston, have voted to proceed with construction of the proposed George F. Baker Clinic, a unit designed primarily for the study and treatment of diabetes and other chronic diseases.

The new building will consist of five stories and basement. The exterior will be of red brick with limestone base and trim and copper cornices treated to match the limestone. The unit is designed so that it may become a part of any future development of the property. Heat, light, power, food and laundry service will be furnished from the main hospital building.

The first floor will contain offices, examination rooms, a large routine laboratory, a small research laboratory, a room for metabolism tests, a diabetic foot room and a large class or demonstration room which will be used for clinics as well as for instructing nurses and patients.

The entire second floor will be given over to laboratories. There will be twelve laboratories, but for the present only six of them will be equipped.

The third, fourth and fifth floors will be given over to patients. At the third floor a bridge will connect with the Palmer Memorial building

American Nurse Is Added to World War Painting

The composite figure of an American nurse, representing the Army Nurse Corps, the Navy Nurse Corps and the Red Cross Nursing Service has been added to the *Panthéon de la Guerre*, the famous panoramic painting of the World War. The painting is now in Washington, D. C., where a special building has been erected to house it. The figure of the American nurse is in the foreground of the American section of the painting.

When the painting was first exhibited in France, American nurses were disappointed to find that among the 6,000 life size figures of heroes and leaders of the allied nations no place had been given to the American nurse, more than 10,000 of whom served overseas, according to the A. N. A. Bulletin.

The American Nurses' Association committee, of which Clara D. Noyes is chairman, secured permission to introduce the figure of the American nurse, which was done when the painting was brought to Washington for the George Washington Bicentennial. The painting will remain in this country for exhibition at the Century of Progress Exhibition in Chicago during 1933.

Coming Meetings

American College of Surgeons.
President, Dr. Allen B. Kanavel, 54 East Erie Street, Chicago.
Director general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, St. Louis, October 17-21.

American Dietetic Association.
President, Dr. Martha Koehne, University of Michigan.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, New York City, November 7-11.

American Public Health Association.
President, Louis I. Dublin, New York City.
Executive secretary, Dr. Kendall Emerson, 450 Seventh Avenue, New York City.
Next meeting, Washington, D.C., October 24-27.

New Garland Deep Fat Fryer

Entire body of steel — Black ebonite finish — Fryer made with flush front to conform to body of hotel ranges, all working parts concealed — front provided with door, all parts easily accessible — Body thickly insulated with Therminsul. Bowl and top cast iron in one piece, finished in black porcelain enamel — Cleans easily and keeps food from sticking. Top edge extends around bowl — preventing grease from boiling over and running down front of appliance.

Bowl drains from left to right — plenty of space for cleaning.

Top is pitched so grease runs back into kettle.

Rolled front edge same as range.

Robertshaw heat control assures correct temperature — chrome plated fittings prevent corrosion. Wire bottom under basket prevents any contact with heat control rod.

Burner capacity 4,000 B.t.u. or 75 cu. ft. per hour — 530 B.t.u. gas, cuts down to 5,000 B.t.u. Burner always on full until correct temperature is reached — 10 minute recovery — take about 20 minutes to preheat — 390° is frying temperature.

Perfect hot and cold zone maintained, assuring perfect temperature — no sediment or flakes on food which results when cold zone is not maintained. No soggy fry or explosions of grease. Maintains perfect accurate difference between cold and hot zone (40°) at all times — (Pyrometer test).

Pot capacity 35 lbs. of grease.

Blue flame pilot used — lit by opening door — blue flame prevents any carbon.

Heavy tinned basket supported for draining by iron rest at extreme back of appliance — rest not fastened to main top.

Regular equipment includes two bailed pails for draining grease — stored in compartment under bowl out of sight. Also provided with strainer — straining of grease can be done at appliance — saving time.

Portable cover — nickeled finish furnished at extra cost — to cover bowl when not in use.

Any number of fryers can be connected in battery or with regular Garland ranges — provided with back extension when used with ranges. 1¼ manifold.

No.	*Diam. of Bowl*	*Width*	*Depth*	*Height*
514	14″	18½″	26″	33″
718	18″	22½″	30″	33″

Write for further information and prices

GARLAND DIVISION

Detroit-Michigan Stove Company, Detroit, Michigan

PERSONALS

G. W. OLSON has resigned, effective October 1, as superintendent of California Hospital, Los Angeles. He has accepted a position with the Department of Welfare of Los Angeles County to assist in the equipping and opening of the new Los Angeles General Hospital. R. E. HEERMAN, formerly assistant superintendent of California Hospital, has been named superintendent of the institution.

DR. R. C. COOK, formerly assistant medical officer in charge and clinical director, Veterans' Administration Hospital, Fort Lyon, Colo., has been transferred to the Veterans' Administration Hospital, Excelsior Springs, Mo., as medical officer in charge.

DR. HORSEA W. MCADOO, clinical director, Springfield State Hospital, Sykesville, Md., has been appointed superintendent of the institution, succeeding the late DR. EDWIN P. BLEDSOE. Among the institutions with which Doctor McAdoo has been associated are Warren State Hospital, Warren Pa., St. Elizabeth's Hospital, Washington, D. C.; United States Veterans' Bureau Hospital, Little Rock, Ark.

DR. B. A. WILKES has recently been appointed superintendent and consultant, Southeast Missouri Hospital, Cape Girardeau, Mo.

DR. HARVEY B. FRALIC has been appointed chief of the medical staff of the new United States Veterans' Hospital, Huntington, Va. For the past several years he has served as regional medical officer for the veterans' administration in Minneapolis, Minn. The hospital was opened in September. C. H. HIBBARD has been appointed manager, Veterans Administration Hospital, Minneapolis, Minn., succeeding DOCTOR FRALIC.

DR. CHRISMAN G. SCHERF is the new medical superintendent, Sea View Hospital, New York City. He was previously medical superintendent at Coney Island Hospital, Brooklyn, N. Y.

R. A. BATES, Davenport, Iowa, has been named superintendent of Ball Memorial Hospital, Piqua, Ohio, succeeding CORA B. ANDERSON. This is the first time since it was founded over twenty-six years ago that the hospital has been under the management of a man. Women superintendents have been the rule previously.

FLOSSIE GRAVES has been appointed superintendent, Methodist Hospital, Peoria, Ill. She has been associated with the institution for the past five years, the last four years as assistant superintendent.

SISTER ODA, superintendent, Sacred Heart Hospital, Eau Claire, Wis., for the past six years, has been named superintendent, St. Mary's Hospital, Streator, Ill., where she succeeds SISTER NAZARIA. SISTER ODA'S place at Sacred Heart Hospital has been taken by her own sister, SISTER JOSEPHA, superintendent for the past six years of St. Vincent's Hospital, Green Bay, Wis. SISTER JOSEPHA had served as superintendent of Sacred Heart Hospital a number of years ago. SISTER THEODOSIA is the new superintendent at St. Vincent's Hospital, Green Bay, Wis., succeeding SISTER JOSEPHA.

ETHEL W. ORMSBY has been appointed superintendent, McComb City Hospital, McComb, Miss. During the past eighteen months she has been studying hospital administration at Cincinnati General Hospital, Cincinnati.

KATHERINE MITCHELL THOMA, director of dietetics, Michael Reese Hospital, Chicago, has been sent to China by the Rockefeller Foundation for a year's research work. Her assistant will remain there two years.

SISTER ROSE has recently resumed her position as superintendent, St. Andrew's Hospital, Bottineau, N. D., where she had been superintendent from 1920 to 1930.

ANNA K. VOGLER, formerly superintendent of Flower Hospital, Toledo, Ohio, was recently appointed superintendent, Riverside Community Hospital, Riverside, Calif.

DR. WILLIAM E. WALDROP, Parma, Idaho, has been appointed commandant of Idaho State Soldiers' Home Hospital, Boise, Idaho, succeeding E. G. BURNET.

FRANCES C. POMEROY has recently assumed the superintendency of General Hospital, Saranac Lake, N. Y., succeeding MRS. EDWARD COOK.

NELLIE G. BROWN has been named acting superintendent, Ball Memorial Hospital, Muncie, Ind., to fill the vacancy created by the death of HAROLD K. THURSTON.

HOSPITAL AND INSTITUTION SILVERWARE

Victor Sanisil Ware

SILVERWARE of a good quality is as essential for the comfort and convenience of patients as the food it is especially designed to carry. Note the simple lines and construction, seamless bodies and rounded corners of the service shown above. • These pieces are heavily silver-plated on 18% nickel silver. Just the right weight and economical to use. Very moderate in price. Catalog No. 41-MH will be sent upon request.

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PERSONALS

MILDRED LAIRD has been named general superintendent, Gaston Sanatorium, Gastonia, N. C., succeeding MRS. B. M. SIGMON, resigned.

MONTA BANE has succeeded EDNA M. EBERL as superintendent, Bozeman Deaconess Hospital, Bozeman, Mont. MISS BANE was formerly superintendent, Butte Deaconess Hospital, Butte, Mont. Previous to that she served as superintendent, Sidney Deaconess Hospital, Sidney, Mont., for seven and one-half years. CORA MENELEY, formerly on the staff of Butte Deaconess Hospital, has been named assistant superintendent and business manager of the Bozeman institution.

SISTER M. BERNARD, superintendent, Mercy Hospital, Wilkes-Barre, Pa., died recently. She had been superintendent of the hospital for many years and was well known in the hospital field.

ANNE REECE QUINN was recently appointed superintendent of Randolph County Hospital, Asheboro, N. C.

H. GLADYS COLLINS, formerly superintendent of Marietta Phelps Hospital, Macomb, Ill., is now superintendent at Grant County Hospital, Marion, Ind., where she succeeds OLIVE M. WEAVER.

EMMA KELTING, superintendent of nurses, Chicago Lying-in Hospital, Chicago, has been appointed acting superintendent of the institution pending the appointment of a permanent superintendent.

WILLIAM P. BUTLER has been appointed manager, San Jose Hospital, San Jose, Calif., following a connection with the Alameda Sanatorium, Alameda, Calif., in the same capacity.

GERTRUDE HARMON recently became superintendent of Edwards Hospital, Corbin, Ky.

CHARLOTTE PALMER is the new superintendent, Angelus Hospital, Los Angeles.

Munificent Gift to Aid Cancer Research Announced

What is to be known as the International Cancer Research Foundation has been established through the generosity of William H. Donner, retired steel manufacturer, Villanova, Pa., who has donated $2,000,000 to promote cancer research throughout the world.

The income from the fund is to be apportioned to institutions throughout the world, not more than 35 per cent to any one and not more than from 50 to 60 per cent to institutions within the United States.

Mr. Donner is president of the foundation; Thomas S. Gates, president of the University of Pennsylvania, Philadelphia, is vice president, and the directors are Edward R. Weidlein, Mellon Institute for Industrial Research, Pittsburgh, and former Senator George Wharton Pepper, Philadelphia.

Hampton Institute Will Hold Health Conference

A health conference will be held at Hampton Institute, Hampton, Va., October 14 and 15, under the auspices of the school of nursing. The conference will be open to public health nurses in the state, health teachers of the Y. W. C. A., members of parent-teacher associations and all other interested persons.

Directory of Hospital Librarians to Be Compiled

Information is desired for the directory of hospital librarians and the directory of hospital libraries to be included in the new "Bibliotherapy —a Manual for Hospital Librarians," now being compiled by the American Library Association's committee on hospital libraries. Hospital and medical librarians, state, county and city hospital library supervisors and librarians for the blind are requested to cooperate by sending information for use in these directories to the committee chairman at 1645 Peachtree N. W., Atlanta, Ga.

The following is indicative of the information desired, though any pertinent or special information may be of use:

Position in library, whether a library school graduate, if a volunteer or paid worker and if in charge of both medical and patients' libraries.

Statistics and full information concerning the hospital, including whether there are medical students and student nurses. A copy of the legislation authorizing the hospital library or the hospital library supervisor is requested.

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Produce your facts!"

WHEN he's challenged, the salesman who claims his sheet is "as strong as Pequot" sometimes can actually show you test figures that apparently support his contention.

But ordinary tests, as you know, can be made to prove almost anything! Get together several such reports and they're likely to contradict each other flatly. There must be a "nigger in the woodpile!"

There is! Such tests are based on too *few* samples, *hand-picked* samples, or on tests made at different times, on different machines. W. F. Edwards, leading textile testing authority, took especial pains to eliminate these breeders of conflicting claims in setting up the basis for the test summarized at the right.

The overwhelming weight of evidence—evidence based on a truly scientific test—is in favor of Pequot. When goods are offered "as strong as Pequot" compare the claims with these established facts! Pequot Mills, Salem, Mass. Selling Agents: Parker, Wilder & Co., New York, Boston, Chicago, San Francisco.

PEQUOT SHEETS

PEQUOT SHEETS AND PILLOW CASES

DATA on TESTS for QUALITY of Sheets and Pillow Cases

Basis of Testing Procedure

W. F. Edwards, leading textile authority, recommends the following three conditions in *any* textile test, to assure thoroughly impartial results:

1 Samples should be purchased in the open market by the laboratory or by some other disinterested party—never obtained from the manufacturer.

2 Since buyers are interested in the *average* run of quality, there should be a representative number of samples of each make; and these should be obtained from as many different sources as possible, so as to be representative of different lots of fabric.

3 Tests to be definitely comparable should be made under exactly the same conditions—this means at approximately the same time, on the same equipment, and by the same individual.

Conduct of Test No. 54,947

The first test of sheets to meet all these conditions was conducted by the U. S. Testing Co., under the direction of A. E. Davieau, late in 1931.

Pequot and the 8 best-known trade-marked brands of sheets in the 68 x 72 or comparable constructions competitive with Pequot were tested.

Ten sheets of each brand were purchased by the testing laboratory from dry goods stores in 24 different cities. No selection of samples was made at any point in the procedure—they were tested exactly as purchased.

Each brand was subjected to 430 separate tests, uniformly conditioned.

The results are the first known *authentic* data on the relative quality of the sheets tested.

RESULTS
Established by Test No. 54,947

1 **Pequot was strongest before washing.**

2 **Pequot was strongest after 100 washings.**

3 **Pequot strength was the most consistent.**

4 **Pequot had least variation in weight.**

5 **Pequot had least sizing—less than half that of any other brand tested.**

6 **Pequot had less than average shrinkage.**

Clip out and file this memorandum.
It will clear up many half-truths with cold *Facts.*

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

How to Maintain a Smooth Running Dietary Department

By LENNA F. COOPER
Supervising Dietitian, Montefiore Hospital, New York City

THE modern hospital with its hundreds and perhaps thousands of beds presents one of the most intricate problems of large group living. For many centuries there have been inns, hostelries, schools and even hospitals intended for collective living, but these have been simple affairs compared to the skyscraper hotels, apartment houses and hospitals of today.

Why all these massive buildings? Why do we huddle together in such numbers? The answer is —Industry. For many centuries man was, comparatively speaking, a lone worker. He owned his own tools and often developed a high degree of skill. Gradually he learned to work with others and there are some notable examples of early collective industry, such as the Pyramids of Egypt, built hundreds of years before Christ. In this effort, which required hundreds of men working for many years, massive stones were placed without the aid of machinery or electricity. No doubt this required organization and careful planning.

Later, under the feudal system, men grouped themselves about a leader, the owner of an estate. When this system broke down trade guilds—forerunners of our trade unions—sprang into existence to afford protection to the groups already formed. Factories developed—not the kind we know today, but groups of men with their own tools, such as the hand looms on which all cloth was made until the eighteenth century, when several inventions, known as the Great Inventions, led to the development of the power loom, thus introducing machinery owned by a proprietor instead of by the worker. Machinery has multiplied tremendously and our modern factories have become marvels of science and ingenuity. They sometimes bring thousands of men under one roof. These factories are sometimes multiplied many times in one locality and we find the modern city with its schools, colleges, hotels, stores, office buildings and hospitals. Our mode of living is determined by our industrial conditions.

Our first hospitals were more like inns intended for the sick wayside traveler, or like homes for the indigent, but they were never planned to care for great numbers. There were occasions, however, when some great emergency brought many sick together. Florence Nightingale tells of having 4,500 wounded soldiers in one hospital during the Crimean War, in 1854. Having been born with a remarkable mind, executive ability and a commanding personality, she did wonders in relieving the chaotic condition and evidently discovered and developed many principles of hospital administration that are still applicable today.

In her books, "Notes on Nursing" and "Notes on Hospitals," written seventy-five years ago, she discusses such topics as (1) the site, recommending that the axis of the hospital run north and south, so as to permit of east and west windows to give the maximum of light; (2) the size of the ward, recommending twenty to thirty-two beds; (3) the space allotment per bed, eight feet by twelve feet; (4) impervious material for walls, ceilings and floors; (5) ward furniture and bedding, suggesting 5 per cent "allowance for deterioration" (one of the first estimates on depreciation); (6) sculleries, kitchens and laundries. She describes a scullery as a place for "ward cookery" which should be large enough to permit the assistant nurses to sit in and have their meals comfortably. She also says that "the

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WITH Jell-O at a new low price, and with its many possible service variations, you should have "America's Most Famous Dessert" on your menus every day.

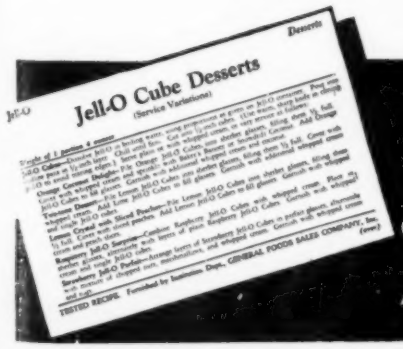
For instance, Jell-O cube desserts are attractive and economical; simple to prepare and serve; colorful, appetizing, and popular.

All of the six pure fruit flavors of Jell-O combine well with fruit—fresh, cooked, or canned. It's a smart way to use fruit left over from other uses.

One of our tested quantity recipe cards gives the simple directions for cubing Jell-O, and includes recipes for five service variations. These will suggest other possibilities to your chef.

Send for this card for your file. And if you would like other tested quantity recipes for new Jell-O salads or desserts, check what you want on the coupon.

Remember there is only one Jell-O, and seven out of ten will accept no substitute.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Jell-O Cube Desserts

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There is only one JELL-O

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This coupon will bring you the tested quantity recipe card for Jell-O Cube Desserts. For other new recipes, check below: (M. H.—10-32)

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Write your name and position on your business letterhead. Pin this coupon to it. Mail to Institution Dept., General Foods Sales Co., Inc., 250 Park Ave., New York, N. Y. In Canada, address General Foods, Ltd., Cobourg, Ont.

best sink for a scullery is the new white porcelain sink, recently introduced, with hot and cold water laid on." She states that the kitchen should be away from the wards and gives reasons for this plan. Fuels she discusses, stating that coal is cheapest for boiling on a large scale, that steam is best for stewing, but that gas is most convenient for preparing extras, although more expensive. There follows a page on the placing of equipment.

In speaking of the laundry, she recommends laundry chutes for soiled linen and says "the excellent new washing, drying and wringing machines lately invented are so numerous that it would take too long to enumerate them . . . but every day brings in fresh inventions, and a reformer is always adopting the good ones."

She Was the First Dietitian

It seems that central service must have originated about that time for she also describes a food service in which "each man's portion is served him hot from the kitchen, not cut up laboriously by the nurse, or weighed as was done in another hospital." She remarks that "if the patient can get the divided portions hot from the kitchen, it is much preferable."

After discussing the importance of variety and the proper cooking of food, she says "I have often been surprised by the primitive kitchens of some of our civil hospitals with which little variety of cooking is possible. It shows how little diet and cooking are yet thought of as sanitary and curative agents. . . . It is singular that while so much care is taken to provide good medicine properly made up, so little care is bestowed on the cooking of that which is of more importance than most medicines."

Her first administrative problem undertaken at Balaclava was that of food service, including the setting up of several extra diet kitchens where gruels, broths and sickroom delicacies were prepared by the hundreds. Because of her understanding and her activity along dietary lines, I believe, we have a right to claim her as our first dietitian, while also honoring her as the mother of nursing.

The dietitian's administrative problems really begin with the building in which her department is housed. It is as important in a hospital as in a factory that the work be properly routed and scheduled. Therefore it is important to study the relationship of the subdivisions, such as the vegetable rooms, bakery and butcher shop, and also to inspect equipment, floors and walls. While it would be exceedingly unwise for the dietitian to suggest any major changes until she has had several months in which to observe and study the needs, she should be ready when the proper time comes to advise regarding improvements. What, then, does she need to know about building and remodeling?

First of all she must decide on the type of food service that is best adapted to the architectural features of the building. If the building is of the stack type, that is, several stories in height, central service would seem most desirable, since the food may be transported by perpendicular lines with elevator and dumb-waiter service. But low buildings of one or two stories, with long corridors, necessitate the transporting of food by truck. When large numbers of people are to be served, it is almost imperative to serve the wards either directly from the truck or from steam tables in ward pantries, the latter allowing for a reheating of food and a little daintier service. Electrically heated trucks permit also the serving of food "piping hot" without transference to a steam table.

How and where the dishes are to be scraped, washed and stored must be considered. Every function to be performed must be reviewed in order to plan for the place of the performance and the securing of equipment necessary for it. How many times closets for towels and cleaning supplies are forgotten. Nothing gives more satisfaction to a fastidious worker than well ventilated closets for mops, pails and brooms and for dish towels and cloths.

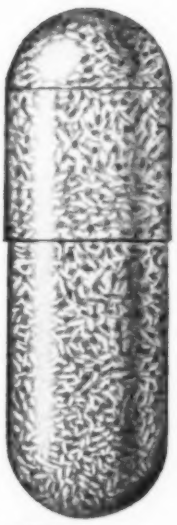
Home Baking Saves Us $400 Monthly

Whether the hospital is to bake or not to bake is another question that will influence building plans. In making a decision on this point the size of the hospital or the number of people to be fed must be considered, the cost of both raw materials and labor required to produce the desired baked goods, the cost of installation and upkeep of the equipment, the cost of fuel and, last but not least, the satisfaction derived from the homemade products. From the standpoint of satisfaction there is little that need be said on the baking of all kinds of pastries. Even the small hospital can well afford to have its own pastry cook. I doubt the advisability of baking bread and rolls for small hospitals but do advise it for large ones.

After a careful study of this problem at Montefiore Hospital, New York City, where we serve 1,150 people per day, including employees, it was found that we could bake our own bread and rolls for a little more than half what it would cost to have it done outside. This of course did not take into consideration interest on the investment of ovens and machinery, depreciation and other overhead expenses that a commercial firm

What should a Wheat Cereal contain?

THE WHEAT BERRY, as nature designed it, is composed of three important parts — the bran, the endosperm and the embryo. Each is a source of one or more vital elements essential to optimum nutrition. A wheat cereal, then, to provide all possible nutritive value, should contain these three parts in their *natural* state. To discard any part, or to destroy its value by processing, reduces the dietary value of the cereal. To help those who direct diets to recognize quickly and easily the color, texture and specific dietary value of each of these three parts—a giant "wheat berry" capsule has been prepared.



This "Wheat Berry Capsule" shows exactly what a Wheat Cereal should contain

This capsule, when emptied upon the accompanying demonstration chart, shows clearly how the three parts of a wheat berry should look when converted into a wheat cereal. In the capsule the bran, endosperm and embryo are separated just as they are in the wheat berry. First come BROWN particles (bran) rich in protein and minerals; then the WHITE particles (endosperm), a valuable energy source; then the YELLOW particles (embryo) rich in vitamins B and E, a good source of vitamin G, and a fair source of vitamin A.

● Ralston Wheat Cereal contains the three important parts of the wheat berry. In addition, Ralston contains 2½ times the amount of vitamin-rich wheat embryo normally found in whole wheat. Ralston does not contain the coarse irritating outer layer of bran.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

Fill in the coupon below and the "Wheat Berry Capsule" and Chart will be sent to you at once.

RALSTON PURINA COMPANY, 470 Checkerboard Square, Saint Louis, Missouri

Please send me, free of charge, the new "Wheat Berry Capsule" and Demonstration Chart.

Name.....

Address.....

City.....*State*.....

This offer is limited to residents of the United States

would have to consider. Our saving amounted to approximately $400 a month. A baker and helper bake 1,600 to 1,700 hard rolls a day, 300 to 500 pounds of bread and all pies, cakes and cookies. There is no comparison in the degree of satisfaction given.

In the selection of new equipment the points about which we must make decisions are: Will it do the work expected? Is it of the right capacity? Is it too large or too small? With what fuel can it best be operated? Is it equipped with safety devices? Can parts be obtained quickly? Is it easily kept clean and in a presentable condition? Is it durable? What is its cost?

The last two questions should be considered together. The durability depends upon the material used in the manufacture and construction. The new noncorrosive metals are attractive and probably will last longer than other metals.

In order to work efficiently with the architect,

MONTEFIORE HOSPITAL PANTRYMEN'S ROUTINE

I. The hours of duty for pantrymen are:
6:50 a. m.—10:00 a. m.
11:45 a. m.—2:30 p.m.
4:30 p. m.—7:00 p. m.
} or until assigned work is finished.

II. Meal hours in the Porters' Cafeteria are as follows: Breakfast 6:15-6:45 a. m. Dinner 11:15-11:45 a. m. Supper 4:15-4:45 p. m.

III. Uniforms shall be worn when on duty. Clean uniforms will be exchanged for soiled ones at the Linen Room on Thursday 9-11 a. m. When necessary to obtain them at other times, written permission must be obtained from the head of the department.

IV. Smoking is allowed only in the employees' dining room and in the dormitory. Repeated offenders are liable to discharge.

V. Report at Main Kitchen for food truck at the following hours: 6:50 a. m., 11:45 a. m. and 4:45 p. m. (on Mondays and Wednesdays report at 4:30 p. m.). Report at Diet Kitchen for truck immediately after delivering to ward from the Main Kitchen, unless requested to report earlier.

VI. Other duties:

1. Wipe shelves for dishes with a damp cloth. Clean all crevices with brush or knife. Wipe cans and jars—this may be done while the meal is being served.
2. Wash inside of ice box; clean drain pipe at least once a week. Keep milk can clean and covered.
3. Scrape, wash and dry all dishes, glassware and silver. Place on shelves in neat order.
4. Exchange dish towels every day at least and more often if necessary.
5. Clean tray under gas range and the bars above.
6. Clean shelves for dishes in steam table; dry thoroughly to prevent rusting.
7. Change water in steam table and clean the water pan every second day. Wash and polish outside of steam table every day.
8. Clean food trucks both inside and out. trays to truck and return to Diet Kitchen. Wash
9. Return clean Diet Kitchen dishes and empty food containers, bottles, etc., and return to Main Kitchen. Eggs and foods which are kept from one meal to the next must be put in pans or dishes belonging to the ward.
10. When scraping dishes, place the edible food waste (that which could have been eaten) into the smaller can. Liquids are poured into the sink. Peelings, etc., are put in larger can. Food waste must be taken to the incinerator room to be weighed at the following hours:
    9:00-10:00 a. m.
    1:30-2:30 p. m.
    6:00-7:00 p. m.
11. Wash garbage cans after each meal and return to ward—keep covered.
12. Wash floor of pantry after each meal. Empty the water into sink in porter's closet—not in the pantry.
13. Wash tile walls whenever necessary.
14. Dust with special brushes in the porter's closet over head pipes and the walls once a week.
15. Get pantry supplies Wednesday, 11 a. m.
16. Get household supplies Friday, 11 a. m.
17. Clean glass doors in pantry at least once a week.
18. Keep supply closet clean and orderly.
19. Clean silver once a week.
20. When food is spilled from truck in transit, deliver truck to ward and return immediately to clean up.

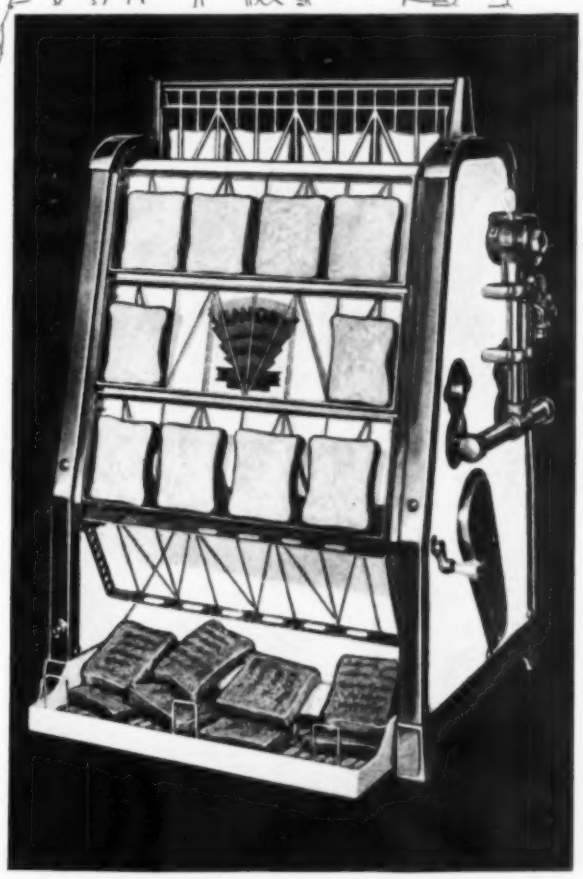
"The SAVORY toast is coming! OH, BOY!!"

TALL nurses, short nurses, slim ones and plump—they are all welcomed when they bring crisp, appetizing Savory toast to the private rooms and wards.

Toast made on the Savory radiant gas Toaster has a crispy crust and a soft warm heart. It is more digestible because of the Savory pre-cooking process, more tempting because of its golden-brown color, and more tasty because of the caramelizing of the sugar content. Dietitians as well as patients acclaim Savory Toast. Every slice is *good*. The Savory radiant gas Toaster can't burn it; there is no wastage as there is with other types of toast-making machines.

"Savory Toaster costs little to install"

The Savory radiant gas Toaster is reasonable in price and from $30 to $50 cheaper to install than other kinds. Its upkeep is so low as to be almost unbelievable. A single model PQ Savory radiant gas Toaster makes as many as 720 slices of perfect and tempting toast per hour at a cost of only 1¢ to 4¼¢.



720 slices of perfect toast per hour—that's the capacity of this Model PQ Savory radiant gas Toaster at a cost of only from 1¢ to 4¼¢. Sizes to meet every need.

Learn the experiences of other hospitals

All over the country hospitals large and small are using Savory radiant gas Toasters today because they have found that they make the most toast at the least cost. Fill out the coupon below. Let us send you a list of hospitals that have established "Savory" as standard.

SAVORY radiant gas TOASTERS

SAVORY, Inc., Dept. MH-10
591 Ferry Street, Newark, N. J.

Please send me a list of hospitals now using Savory radiant gas Toasters, tell me more about the toasters, and send me your book, "Better Toast at Lower Cost."

*Name*_____

*Hospital*_____

*Address*_____

the engineer or the building contractor it is important to be able to speak their language—the language of floor plans drawn to scale—to be able to visualize plans from a blueprint and to read specifications intelligently and carefully. Much thought should be given these things, for once the contract is drawn changes are expensive.

With the problems of the physical plant settled, the dietitian will then turn her attention to the management of both personnel and material things.

Personnel management is probably the most important function of the administrative dietitian, for the control of the material things—food, dishes and equipment—is effected chiefly through the personnel. Every department head should be grounded in the principles of personnel management. We are indebted to industry for most of our knowledge of this subject, hence references to industrial organization and management may be read with profit. How to select, how to train and how to keep desirable employees are all questions of vital importance. Much may be learned of the applicant through references but more is learned from an interview. The training should be begun the first day of employment even though the employee gives assurances that he knows how to perform the assigned task. It is important that he know the dietitian's way. This may be accomplished by personal supervision and also by standardized practice sheets, outlining in detail steps in the performance of the task and the time assigned for each duty. The accompanying outline of duties of pantrymen will illustrate this point.

Courteous Treatment Wins Employees' Loyalty

Labor turnover is like a clinical thermometer. It will tell you when something is wrong but the diagnosis is left to further study and investigation. The turnover is due to withdrawals and discharges. If the withdrawals are high, one would suspect unsatisfactory working conditions, or bad management on the part of the head of the department or her subordinates. Personal reasons, such as illness at home or the offer of a better position, are sometimes given by the employee to cover up his dissatisfaction. Hence if personnel reports are to mean anything an effort must be made to obtain the facts in the case. A high percentage of discharged employees indicates lack of care in selection. References should be investigated if possible before employment is given. This is not always possible, especially when vacancies occur suddenly. A waiting list of investigated applicants is desirable and it is generally possible to have such a list now that jobs are at a premium. The turnover in city institutions is always high compared to rural districts. That the turnover this year is much less than in previous years, on account of the depression, is shown by a comparison of our 1929 figures with those for 1931, as analyzed in the accompanying table.

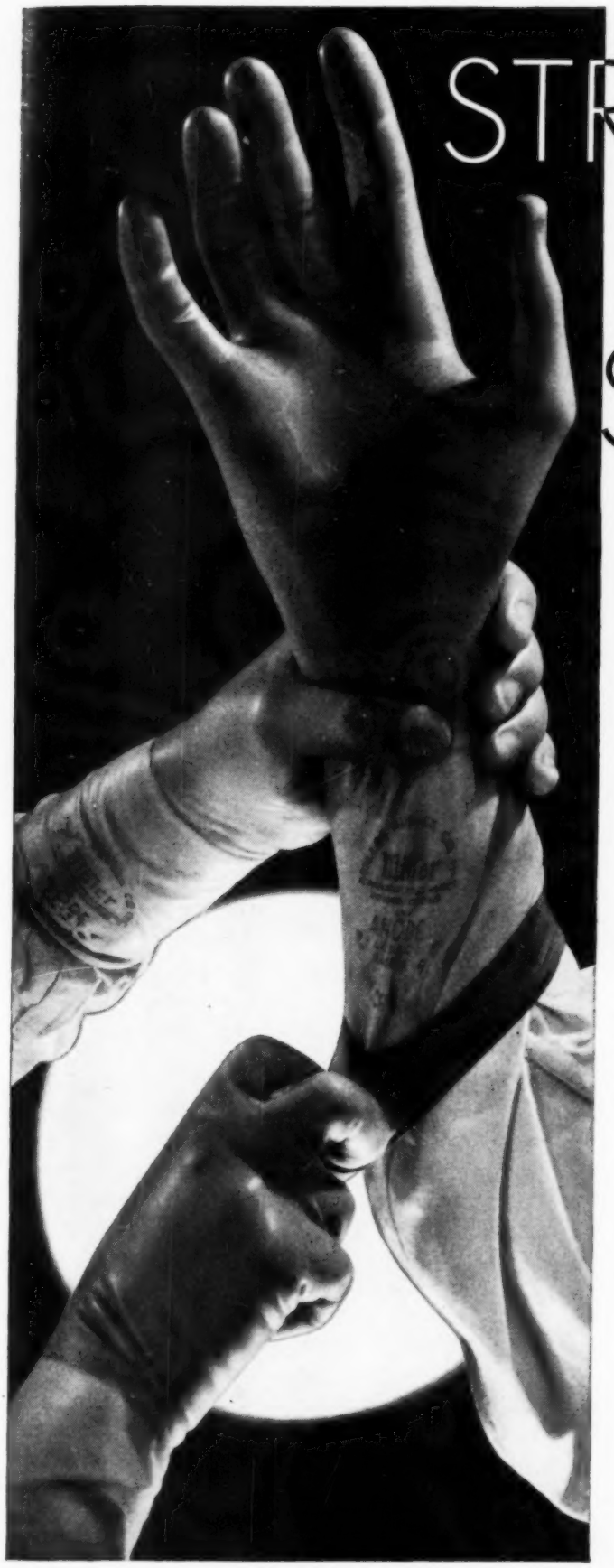
Often more or less obscure reasons affect an employee's decisions. The general atmosphere of the hospital, whether it is kindly or critical, the confidence or lack of it between employee and employer, the fitness of the employee for his particular job, all give rise to content or discontent. The hospital that can offer clean airy rooms and attractive dining rooms to its employees reduces its turnover. Good wholesome food, including milk, eggs, fruit and vegetables, not only keeps him physically fit but makes of him a satisfied worker. Men who are treated as gentlemen act as such.

It is bad psychology, I believe, to serve leftovers as such to employees, thus making them feel that the hospital's attitude is one of lack of appreciation—anything being good enough for them. I also

ANALYSIS OF LABOR TURNOVER IN THE DIETETIC DEPARTMENT OF MONTEFIORE HOSPITAL, 1931.

Voluntarily Withdrew:	
Reasons:	
Better wages or position	13
Dissatisfied	3
Ill health	3
Illness in family	1
Moving to another locality	3
Going to school	1
Work too hard	4
No reason given	3
Failed to report	2
Total	33
Discharged:	
Reasons:	
Incompetent	6
Untidy	1
Drunkenness	4
Theft	1
Failure to obey orders	4
Uncooperative	7
Unable to pass foodhandlers' exam.	2
Total	25
Temporarily Employed: (Not considered in turnover.)	6
Transferred to Other Departments: (Not considered in turnover.)	4

Years	*Average No. Jobs*	*Total No. Leaving*	*Percent. Turnover*
1929	49.5	211	426
1931	70	68	80



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. . . and the Wrist is virtually tear-proof

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It has freed their fingers from the heavy grip of old-time cumbersome acid-cured gloves. It has enabled hospitals to practice real economy on their glove accounts.

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believe it inadvisable to segregate this group of men workers. I have had occasion to observe a group of porters and orderlies in a cafeteria for men only and served by men. They were disorderly and discourteous to those who served them until women servers were put behind the counter, when a change in their behavior was noted at once. Later the maids were allowed to pass down the same line, afterwards disappearing into another dining room, adjoining the men's dining room. The result is that these men are now gentlemen instead of ruffians and I see no ill effects upon the women's behavior.

Daily Food Cost Sheet Is Invaluable

There is no quality more desirable in an executive than absolute justice. All complaints and grievances should be investigated. If an employee is wrong, try to see that he understands why you decide against him. Conferences with employees are helpful because faults and failures in service and in personalities may be discussed impersonally. More important still, standards and ideals may be established by a little merited praise. Commendation is more effective than criticism, although one must not overlook failures either. Sometimes a slight reward with some publicity attached to it produces increased effort. When people are doing the same kind of work, as for example pantrymen, inspection of each other's work is beneficial. A plan of weekly or biweekly inspection of grading ward pantries is proving helpful in Montefiore Hospital in establishing standards for this group of workers. Anything that increases a man's self-respect is reflected in his attitude toward his work. The change from dark ugly service coats to white ones symbolizes the high ideals of cleanliness expected of the workers.

In dealing with employees it must not be forgotten that each one is an individual human being and quite unlike any other. He is a problem worth studying. When he is unsatisfactory in one job the tendency is to discharge him. Why not try him at some other kind of work? A table waiter who did not get along with the other waiters did excellently when assigned to a job where he could work more or less alone. Another worker who was a relief man and was unsatisfactory in his work evidently could not remember so many details and is now most happy as a dishwasher with routine work. The dishwashing machine was never better cared for than at present.

Much might be said of the management of material things—food, dishes, silver, linen, equipment, floors, ceiling and walls. Suffice it to discuss at this time the management of food and dishes.

The objective of food service is to give satisfaction and optimum nourishment at a minimum cost. To give satisfaction the dietitian must know something of the food habits and tastes of the groups to be served, must be able to serve the food hot or cold as desired, must convince the groups of her interest in their desires and show them that she is not an unapproachable autocrat.

The psychology of feeding people is as important as what you feed them. One great advantage in having ward or contact dietitians is that the patient feels that someone is interested in his welfare as it pertains to his food and if he has a grievance, there is someone to adjust it for him. Often slight adjustments of a diet add greatly to his comfort. If these are impossible an explanation should be given him.

Food management involves (1) menu making, (2) purchasing or requisitioning, (3) receiving, storing and preparation, (4) safeguarding against waste, and (5) budgeting and accounting.

Budgeting and accounting should go hand in hand. The only sure way of staying within one's allowance is by knowing each day the total expenditures to date. A daily food cost sheet is invaluable. It is desirable to have this service from the accounting department but if that is not available, a simple form may be used to record each day's requisitions, unit price and total cost.

A Record in Reducing Food Waste

Waste is a specter that stalks everywhere. It may be found in overpurchases or unwise purchases, in the refrigerator, in the preparation and in the distribution of food. In a hospital, the greatest source of waste is in the wards. This varies in quantity for the following reasons: (1) the quality of the food served; (2) poor cooking; (3) careless handling of food; (4) too frequent serving of same dish; (5) the size of servings; (6) the severity of the illness of the patients; (7) the type of medication and treatment; (8) the amount and nature of food contributions from the outside.

The above causes suggest their own remedy. Just what is a reasonable waste is hard to say. We seem to have no standard. Dr. Ernest E. Irons,[1] commandant, Camp Custer Base Hospital, Battle Creek, Mich., did a notable work in reducing waste to a minimum during the World War. The garbage was divided into edible and inedible food waste and was taken to one central station where it was weighed and inspected. He was able to reduce the edible waste to less than one ounce per capita per day. This of course was accomplished under military conditions when even sick men felt the necessity of doing their share in the food conservation movement. Reports from each ward were sent to

[1] Detecting Food Waste, THE MODERN HOSPITAL, Feb., 1920.

the commandant's office who in turn sent them back to the wards with information not only of each ward's record but of the records of all the wards, so that each charge nurse knew how her ward rated. This publicity was a powerful incentive to the control of food waste.

From some unpublished data of the Veterans' Administration, Washington, D. C., the average from twenty-two hospitals for one month recently was 7.2 ounces per capita per day of edible waste, and 6.1 ounces of inedible waste.

Standards Are Needed

In August, 1931, a study of food waste was undertaken at Montefiore Hospital. The first month's average was 15 ounces. By suitable publicity, this was gradually reduced to 9 ounces. These figures are somewhat higher than those of the Veterans' Administration but the type of patient is quite different at Montefiore Hospital where only chronic cases are received, there being many cases of advanced tuberculosis, cardiac diseases and cancer. Is this waste too high for this type of hospital?

We face about the same situation in regard to breakage of dishes. What is a normal allowance for hospitals? Restaurants consider 100 per cent normal. But hospital dishes are ordinarily handled by many more hands than restaurant china, and frequently seconds are used. These dishes not only break more frequently on account of some imperfections but they stack poorly and insecurely.

I had occasion recently to compare figures from two hospitals. The breakage was 75 per cent or six dishes per person for the year. The other hospital had a breakage of twelve and one-half dishes per capita or 154 per cent. The service and the type of patients were entirely different.

A Field for the Research Worker

What is a standard for hospitals and should the type of service make a difference? The same question might be asked of many commodities and practices. Does it not seem fitting that some of our associations, national, state or local, should undertake to study some of our unsolved problems and to collect data from which standards could be formulated?

We often complement ourselves on the fact that we are living in a wonderful age, so far advanced over a generation or two ago, yet when we find ourselves still discussing the problems that were in the thoughts of hospital administrators seventy-five years ago, it seems that it is high time we approached them with thoroughness and in the spirit of scientific research.[1]

[1]Read before the New York State Dietetic Association, Albany, May, 1932.

The Function of the Hospital in Training Specialists

The specific interests of the hospital in the training of clinical specialists were summarized by Dr. Louis B. Wilson, director, Mayo Foundation for Medical Research, Rochester, Minn., at the Annual Congress on Medical Education, Medical Licensure and Hospitals, held recently in Chicago. He said:

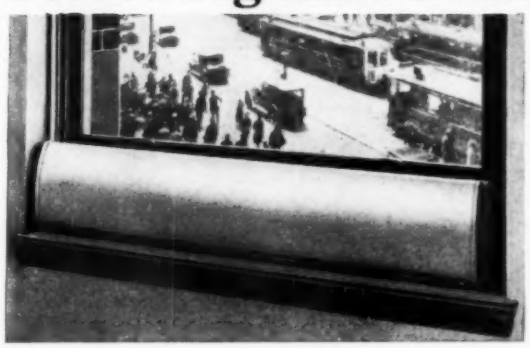
"Hospital authorities are responsible, not only for the general well-being of their patients, but also for the selection of competent men for their professional staffs. These functions for the most part they adequately perform. They are subject to criticism at present chiefly in their systems of internships and residencies. The latter for the most part stimulate specialization too early in the physician's clinical experience, give inadequate experience for checking diagnosis and treatment at necropsy or after the patient is returned to his home, and by brief tenure encourage the tyro specialist to begin special practice with insufficient supervised training. Hospitals without facilities and interested staff personnel sufficient to ensure thorough training in special fields should refrain entirely from residencies confined to those fields."

The Stimulating Effect of Students on Graduates

Whether the same number of nurses would be required if student nurses were replaced by graduates, is a question that cannot be answered by figures alone, a report by Dr. C. P. Knottenbelt, The Hague, in *Nosokomeion* emphasizes.

"It is universally admitted," says Doctor Knottenbelt, "that it is extremely difficult, if not impossible, to keep a staff of graduate nurses in a hospital at a high working standard if they lack the stimulus afforded by the presence of the student nurse who, possibly merely on account of her youth, is frequently more keen, alert and enthusiastic. The very fact that the graduate staff of the hospital is more or less responsible for the training of the student nurse gives the former a keener interest in her work and makes her realize that it is incumbent upon her to keep pace with the ever-changing methods of treatment, both in medical and surgical wards. For this reason, a hospital employing only a graduate nursing staff will experience difficulty in keeping up a high standard of nursing performance."

Protect Against Noise



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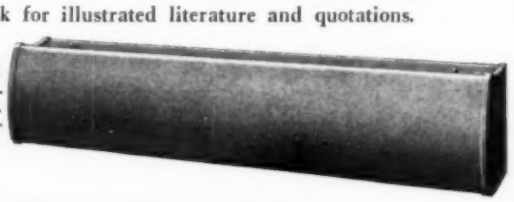

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The China Bowl and Beetle Extracting Bulb of the Sunkist Extractor are acid-proof . . . no metal touches the citrus juice as it flows into the glass, making it most sanitary, efficient and speedy.

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Please send me complete literature on the Sunkist Electric Extractor.

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HOSPITAL EQUIPMENT AND OPERATION

Conducted by C. W. MUNGER, M.D.
Director, Grasslands Hospital, Valhalla, N. Y.

Keeping the Hospital Supply Stocks Mobile

By HOWARD A. MUNSON
Purchasing Agent, New England Sanitarium and Hospital, Stoneham, Mass.

CONDUCTING a modern hospital is not a money-making enterprise. The charges in many of our hospitals scarcely cover the expenses of operation, and the management must be continually trying to cut expenditures, at the same time studying how to increase the income. Unless every department in the hospital is efficiently and economically managed the hospital can quickly become a money-losing enterprise.

Whether the hospital makes a small profit or finds it necessary to use the red ink at the end of the year does not depend entirely upon the doctors and nurses. The medical staff is responsible for the proper care of the patient, but the housekeeping, the culinary, the bookkeeping and the purchasing departments have a responsibility in making the stay of the patient profitable to the institution. With this thought in mind, let us consider how the hospital supply stocks may be efficiently handled.

Until a few years ago the department handling the hospital supplies was one of the most poorly managed departments in many of our large institutions. Unwieldy inventories and poorly stored supplies laid a burden on the hospital that required all the combined efficiency of the other departments to counteract. Some years ago I visited the stock rooms of a large institution where this condition prevailed. I saw sugar, liquid soap, disinfectants, cereals, canned goods and gauze bandages all promiscuously piled together. In one corner there were two stacks of No. 10 canned goods piled to the ceiling. These cases contained a slow-moving and short-lived fruit and many of the cans were bulging at the ends. Others had burst in the cases and the fermented contents were dripping down over the cases below. On some boxes there was a three or four months' accumulation of dust. In these stock rooms there was an inventory of this kind of merchandise that amounted to about $14,000. In fact, if the inventory dropped down to around $12,000 at the end of the year, it was felt that something must be wrong.

It is fortunate for our hospitals that this sort of picture is fast disappearing. There is still reason enough, however, for this discussion of some of the best methods of keeping supply stocks in a healthy condition.

Supply stocks should never be allowed to accumulate. And the best way to keep them from accumulating is by hand to mouth buying. Of course, there are times and conditions when strict hand to mouth buying is not wise, but as a general thing, in this day of fast transportation, it is a safe policy to follow. It is a rather new idea in business, but the business world has been quick to realize its importance. Hospitals must do likewise.

Back in 1915 it was not at all unusual for the hospital buyer, or any buyer for that matter, to lay in a full year's supply of some item. Then conditions gradually changed, and from 1920 to 1924 most concerns were ordering their supplies from four to six months ahead. They kept an inventory on hand that would fulfill their requirements for that period. These same companies today have a stock inventory on hand that would last about one month. Many of the smaller items are now purchased as they are needed, and they never find their way into the modern inventory. Alert concerns in every field are realizing that hand to mouth buying

REAL FACTS ABOUT CLINICAL THERMOMETERS

No. 10, 

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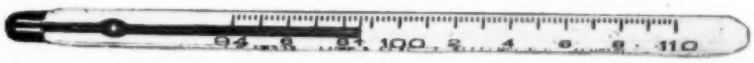
No. 30, 

No. 40, 

IN the State of Massachusetts where rigid laws govern the sale of clinical thermometers, KESSLING THERMOMETER COMPANY, supply nearly 50% of all Massachusetts Seal clinical thermometers, not only for the fiscal year of 1931, but also for the fiscal year of 1930; here are the figures:

	Total Sales	KESSLING THERMOMETERS
1931	178,533	88,274
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helps them keep a smaller average inventory in proportion to their needs, makes it possible to keep their stocks mobile and gives them a turnover that ensures a profit. Sometimes I wonder if all our hospitals are reaping the benefits of this practice.

A Large Inventory Is Dangerous

Closely related to the thought of hand to mouth buying are small inventories and quick turnover. For years we have thought of an inventory as a quantity and we have felt that a huge inventory indicated that all was well with the business. But the business world has changed its idea of an inventory from a quantity to rate of turnover. It has been said that the ideal inventory is in transit. It is certainly true that the rate with which an inventory moves is often the difference between red and black ink at the end of the year.

A large inventory has many disadvantages and dangers. Much has been written about large inventories and they deserve all the harsh things that have been said about them. There is no rhyme or reason for investing thousands of dollars in supplies for the hospital. This is one form of "frozen assets," which after a time will even cease to be assets and will become "white elephants." This dormant money would fulfill its purpose better either drawing interest or in circulation. The hospital can usually use a few of the thousands of dollars lying around in surplus stock. Then, in the large inventory, a considerable loss results from the spoilage of perishable goods, breakage occurs because many of the items are handled and rehandled frequently to make room for incoming goods and damage is caused by the dirt and dust that collect on long stored goods. Then there is the loss from depreciation and from the obsolescence of some goods.

Another great danger in a large inventory is that the buyer and the stock man are almost sure to lose control of it. It gets so large and contains such a diversity of items, that they cannot easily keep an accurate record or quickly remember the different items and the quantity of each on hand. The result is a confused stock room. Many times a quantity of some article is ordered when there is already an adequate supply lost somewhere in an overstocked and disarranged room. The net result is an almost complete lack of mobility.

It is impossible to keep supply stocks mobile unless there is adequate storage space for these stocks. Many of the older hospitals were not wisely planned in this particular. The planners seemed to think that almost any old unused basement room was good enough for a stock room. But it is apparent that stocks cannot be easily controlled or readily moved if they are kept in a dark, damp or dirty basement room where there is inadequate space. The buyer should give the supply stocks the same

consideration that the doctor gives the paying patient. If the supplies are to be kept healthy they must be kept in a storeroom where there is plenty of light, good ventilation and a dry floor space. Good shelf space for the smaller items, ratproof bins for others, wooden racks for drums of liquids and dustproof cupboards for easily soiled supplies are an absolute necessity.

The only safe way to keep a check on the stock room is to give each individual item a designated space and always keep it in that space. In allotting the territory, goods of a widely different nature should be properly separated. Soap and sugar must be kept apart as must also disinfectants and cereals and fine linens and hardware. In the well arranged and not overcrowded stock room there will be no trouble about keeping the supply stocks mobile, the inventory low and the turnover frequent.

Large Orders Are Sometimes Best

Much would be accomplished towards keeping small inventories and stocks mobile if the buyer and the department heads would work together in simplifying styles in equipment and supplies. The average hospital uses entirely too many styles, patterns, forms and designs of different articles. We could reduce our styles of glassware, our designs of carpets, our many kinds and styles of linen, our printing forms, our types of furniture. It is easily seen what this would do to our inventories. And it would be a great boon to the buyer. It would help him to get better prices, for he would buy larger quantities of the one item. It would help him give better service in replacement orders, for he would order from the company that supplied the simplified article, where formerly he shopped around and each time purchased something different. It would not only reduce the inventory of the stock rooms, but it would materially reduce the supply inventory and equipment inventory of every department.

Many times it is wise to buy some merchandise in quite large quantities and in the original packing. This would apply to sheets and blankets. But close competition has made it possible for the buyer to estimate his requirements for six months or a year and effect a good saving by buying large quantities and then drawing his merchandise out in shipments as they are needed. Thus the hospital gets the advantage of quantity buying without the disadvantage of a large expenditure of money or an overburdening of the stock rooms. The danger in this procedure is that the buyer will overestimate his requirements. Then when his contract period expires, the goods not withdrawn will be shipped to him. But with well kept records, under average conditions, the buyer can estimate very accurately his consumption on many of the larger items.

In order to keep supplies in the best condition,

therefore, some good inventory system must be maintained. It seems to me that some form of "perpetual inventory" system is a necessity.

This system consists of a large loose leaf binder with an A to Z index. Under each letter of the alphabet there is room for about two dozen stock sheets. Each item is listed separately on one of these stock sheets. The information on these sheets tells the date of the purchase, the quantity purchased, from whom it was purchased and the cost. These goods are put in their place in the stock room. As a case is taken out the stock clerk makes a record of the date, the quantity removed and the balance on hand. From these sheets the buyer can immediately tell how much of a certain stock he has on hand, when and from whom he purchased the last supply and how much it cost him.

The Value of a "Perpetual Inventory"

This system has many advantages: First, it is invaluable in estimating future requirements. If "futures" are bought, the buyer can tell by this record how much of a certain item he has used in the last six months or year. The consumption of many items remains uniform from year to year. Second, it eliminates the danger of reordering merchandise before it is needed. If the buyer's office is some distance from his stock he may venture to guess that he must be nearly out of some item and give the salesman an order, only to find that he already had a considerable supply. With a well kept stock book at hand this would not be done. Third, it provides a valuable cost record. The buyer can tell by his stock sheet how much he has been paying for any given item over a period of two or three years. He is quickly informed of price changes and the sources from which he has been getting his best prices. Incidentally, such a system greatly simplifies the problem of taking inventory. Two men can take a complete supply inventory of $7,000 or $8,000 in about two hours. Such a perpetual inventory system is invaluable in keeping the stocks mobile and the inventory small.

The main points of this discussion, then, may be summarized briefly as follows: (1) We must choose our merchandise wisely and buy in small quantities. (2) We must keep a small stock on hand at all times to ensure a quick turnover and more profits and to keep our money in circulation. (3) We must have spacious, light, airy and dry storage space for these stocks and have each stock arranged neatly in a space of its own. (4) We must simplify the styles and number of our items so that we shall not have a great diversity of slow-moving stocks on hand. (5) We must keep a complete, up-to-date record of these stocks at all times so that we can tell at a glance the standing of any item.

How Much Water Is Used Daily by the Well Run Hospital?

By C. P. WRIGHT, JR.
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What is the normal daily consumption of water in the well run hospital? This question was asked by R. H. P. Orde, secretary, British Hospitals Association, in a letter to Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y.

"In an interesting article on the water softener in THE MODERN HOSPITAL, for December, 1930,[1] the authors assume that a 200-bed hospital requires approximately 50,000 gallons of water a day," Mr. Orde writes.

"This figure is more than two and a half times in excess of that I have found to be the normal consumption in hospitals of full range and well managed. I conceive that there is no great difference in the water requirements of a full range hospital with you and with us. Have you any data with regard to water consumption?"

To answer Mr. Orde's inquiry, an attempt was made to survey water consumption in a large group of hospitals in New York City and its vicinity. An extensive study, however, was found to be impossible, due to the fact that most of the large hospitals in New York City derive their water supply free of charge from city mains and have no meters and therefore no accurate figures as to water consumption. The study, accordingly, was limited to a smaller group of suburban hospitals for which accurate records were available. The results are shown in the accompanying table.

WATER CONSUMED BY A GROUP OF HOSPITALS NEAR NEW YORK CITY

Hospital	*Bed Capacity*	*Average Daily Census*	*Total Employees*	*Employees Residing at Hospital*	*Employees Residing Out of Hospital*	*1931 Total Water Consumption in Gallons*	*Total Daily Consumption in Gallons*	*No. Gallons Per Patient Per Day*	*No. Gallons Per Lodger Per Day*
I	108	55.7	101	50	51	6,499,372	17,806	319.6	113.4
II	138	115.0	173	158	15	10,486,960	28,731	249.8	99.76
III*	225	151.0	182	123	59	7,418,918	20,326	134.6	61.00
IV	297	167.0	336	176	160	24,248,589	66,434	397.8	132.00
V†	320	224.0	243	149	94	29,920,000	81,972	365.9	175.5
VI‡	660	462.5	485	440	45	32,933,343	90,228	195.0	95.2
Tots. and Avgs.	1,748	1,175.2	1,320	1,096	424	111,507,182	305,497	259.9	122.0

*All hot water softened by standard water softeners except in nurses' home. One ice machine making thirty 100-lb. cakes which made 212.6 tons of ice during 1931.
†Plant includes refrigeration plant, but no swimming pool or hydrotherapy department; limited grounds requiring sprinkling.
‡Includes swimming pool, refrigeration plant, extensive grounds requiring sprinkling.

It is believed that the statistics given in this limited survey will be of interest to the hospital field, and that superintendents of other hospitals

[1] Partridge, E. M., and Bradney, L. L., The Water Softener—An Industrious and Economical Servant, p. 140.

may wish to compare their own experience with that of this group of hospitals in New York City and its vicinity.

Mr. Orde's letter indicates that English hospitals use approximately 100 gallons of water per bed per day. In this particular group of hospitals there is only one that has a consumption of approximately 100 gallons per bed per day. Most of the others have a much higher consumption. Without further study it is difficult to explain this difference. It may be partly due to the water cooled refrigeration plants, the swimming pools, and the more elaborate plumbing appointments that are to be found in American hospitals. It may further be due to the fact that greater attention is given in English hospitals to economy of water consumption.

These figures have seemed worthy of publication, and it is hoped that some individual or committee may be prompted to study this matter in further detail. The findings of such a study should be helpful to hospitals in their efforts to reduce operating costs.

A Surgeon's Glove That Has "Feelability" and Strength

The qualities desired in a rubber glove are thinness, great tensile strength and a flexibility that will permit freedom of movement of fingers and thumbs. Improved manufacturing methods have brought about a glove thin enough to permit the sensitive nerves in the tips of the fingers to register a sense of feel that approaches the ungloved hand. The gloves are made from the pure milk of the rubber tree, and they have shown a tensile strength of more than 5,000 pounds per square inch under test.

Borated Paper Products Produced for Hospital Use

The mild antiseptic qualities of boric acid are provided in a new type of processed paper towels, napkins and toilet tissue. Boric acid is mixed with the paper pulp to form a homogeneous mixture before the pulp is made into sheets. After the sheet has been completely formed it is then coated in a second bath which impregnates the sheet and leaves a final coating of boric acid. This treatment of the paper makes the sheet soft and pliable and of a cloth-like quality.

The mild antiseptic property of the toilet tissue seems to recommend this paper for use in cases of rectal disorders. This tissue is supplied in rolls, and single or double fold.

Rugs and Runners Well Suited for Hospital Floors

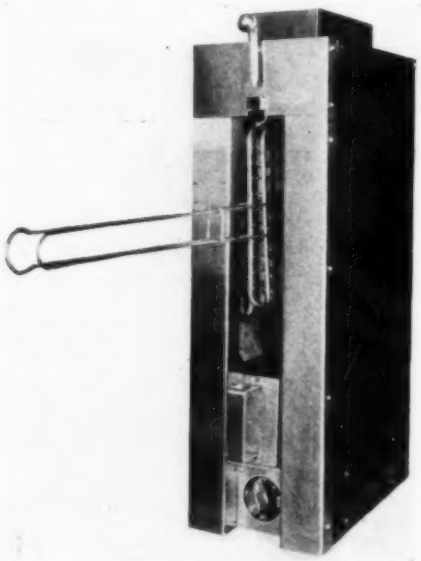
There has recently been introduced to the hospital field a seemingly new idea in rugs and runners. These rugs are made of long-staple, stock-dyed cotton and are guaranteed by the manufacturer to withstand washings without fading.

The rugs are provided in attractive color combinations and are especially designed to lie flat and not wrinkle or curl. These products are believed to be desirable for bedrooms and, because of their fast color and wearing qualities, should be especially suitable for solariums, porches and employees' living quarters. They could also be used in bathrooms or other sections of the hospital where floor covering needs to withstand frequent wetting and washing. The cotton fabric renders these rugs mothproof and their softness, particularly after washing, is an appealing feature.

A New Electric Vertical Broiler for the Hospital Kitchen

Incorporating the qualities of high speed, safety and durability a new broiler has been perfected that produces steaks and chops with that special flavor that is possible only when the meat juices are retained by simultaneous searing on both sides.

A quick loading and unloading grid, an ingenious damper arrangement for regulating heat to give the best results for various types and thicknesses of meat and extremely small space requirements in relation to broiling area, are features of this broiler.



It is an easy matter to broil meat properly when it is done on this vertical electric broiler.

These broilers are made in individual units, designed for banking to any required capacity.